Care Quality Commission

Sandwell and West Birmingham Hospitals NHS Trust

City Hospital

Quality Report

Dudley Rd,
Birmingham
B18 7QH
Tel:0121 554 3801
Website:www.swbh.nhs.uk

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

City Hospital (formerly Dudley Road Hospital, and still commonly referred to as such) is a major hospital located in Birmingham, England, operated by the Sandwell and West Birmingham Hospitals NHS Trust, Serving a population of around half a million people.

It provides an extensive range of general and specialist hospital services. It is located in the Winson Green area of the west of the City. On the City site, there is also a Birmingham Treatment Centre (BTC) and a Birmingham Midland Eye Centre (BMEC).

We carried out an unannounced visit on the Medical Core service in February 16, 2017, followed by a short notice announced inspection in March 28-30, 2017, with another unannounced visit in April 6, 11-13 2017.

We have made judgements about six core services within City Hospital and rated each one individually.

Our key findings were as follows:

- Incident reporting and shared learning needed to be improved across the organisation.
- The trust held 10 quality improvement half days (QIHD) per year during which time staff shared learning and attended relevant training.
- Robust application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist was visually monitored on a daily basis.
- The trust had made a vast improvement in the end of life care service since 2014 inspection.
- We saw examples of positive multi-disciplinary working and staff told us this was consistently good across the trust.
- Infection control had improved since the inspection in 2014, however, this varied across both sites. Mortuary staff were not following the trust's infection control policy. We were not assured the service was protecting mortuary staff and the general public that visited the mortuary from potential health and infection risks, infection control training was not included in the mortuary mandatory training.

We saw several areas of outstanding practice including:

End Of Life Care:

- The palliative and end of life care service integrated coordination hub, acted as one single point of access for patients and health professionals to coordinate end of life services for patients.
- The service provided access to care and treatment in both acute hospitals and in the community, seven days a week, 24 hours a day.

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

Importantly, the trust must:

BMEC-Emergency Department

- Increase availability of specialist medical staff and anaesthetists to minimise the risk that children, particularly those younger than three years of age, who attended department receive timely and appropriate treatment.
- Robust policies and procedures are in place to manage the effective security of prescription forms at a local level.
- The storage of fluids are tamper proof, in line with Resuscitation Council guidelines.
- Patient records must meet standards for general medical record keeping by physicians in hospital practice**.**

Medicine:

- Ensure compliance with the Mental Capacity Act (2005) is documented.
- Ensure attendance at mandatory training is improved.

Summary of findings

- Take steps to reduce delays in the patient journey and ensure people are able to access care and treatment in a timely way.
- Improve the consistency of multi-disciplinary processes and ensure the implementation of consultant led board and ward rounds.
- Ensure patients have access to translation services when required.
- Ensure governance structures are embedded and a structured approach is taken to the identification and management of organisational risk.

Surgery including BMEC:

- Ensure measures are in place to prevent further Never Events to protect patient's safety.
- BMEC mandatory training targets for all clinical staff are met and recorded.

Children and Young People BMEC:

- Improve local governance and ensure risks to the service are escalated, recorded, acted upon and reviewed in a timely manner.
- Medical staffing meets needs of patients and the service.
- Review the storage of emergency drugs and equipment for children and young people
- Age appropriate facilities are provided with separation of adult and children waiting areas and treatment areas.
- Mandatory training targets are met and recorded including paediatric life support.
- A framework for staff to develop and demonstrate competencies to care for children is in place.

Outpatient Department including BMEC:

- Resuscitation trolleys are locked and secured with tamperproof tags.
- Patient notes are kept securely and confidentially.
- Sharps bins and clinical waste are stored securely and safely.
- Consulting rooms in BMEC protect patients' dignity and privacy, and prevent people from overhearing conversations between staff and patients.
- There are improvements with staff completion of mandatory training.
- All staff that carry out root cause analyses are trained to do so.
- The consulting rooms in the BMEC orthoptics department were large, and two or three patients underwent consultations at the same time, only separated by screens. Patients were able to overhear conversations between staff and other patients in the room. Staff told us they were not able to protect patients' dignity and privacy due to the way the rooms were set up, but they had one single room they were able to use if patients expressed concern. We asked staff if they told patients about this facility and if staff offered it to patients for their consultation; Staff told us that the patients only used the room if they raised the issue

In addition the trust should:

Urgent and Emergency care including BMEC:

- The trust should review cleaning schedules and include the windows above the minors' area, which were not part of the housekeeping schedule and had not been cleaned for several months.
- The trust should review action plans from national and local audits, in particular record keeping audits to improve the quality of patient records.
- The trust should improve the communication of waiting times to patients, especially if electronic displays are not in use.
- Look for ways to improve patient privacy in the department.

Summary of findings

- Improve the waiting area and provision of age appropriate toys and games for children and young people in the department.
- Consider introducing an electronic flagging system for vulnerable patients, such as those living with dementia or a learning disability.
- Consider participating in a wider range local and national audits in order to assess, evaluate and improve care of patients in a systematic way
- Staff should routinely assess patients' pain on arrival to the department.
- Introduce a water dispenser in the BMEC ED waiting room to ensure vulnerable patients have quick access to water at all times.
- Implement SLA's with other trusts so that paediatric patients are kept safe at all times
- Improve communication from executive colleagues regarding changes being proposed to the department.

Medicine:

- Review the content of the emergency resuscitation trolleys and ensure security of the contents.

Surgery including BMEC:

- Safety thermometer information should be displayed on the wards. Staff members should be aware of their ward scores.
- Competencies for nursing staff working in surgical specialisms should be revisited after their initial competency 'sign off' stage.
- Patients should be consented for surgery prior to arrival on the ward
- Wider learning should be promoted through complaint trends being shared amongst all areas of the trust
- Ensure all BMEC staff are aware of the duty of candour and when this would be applied, following a notifiable safety incident.
- Ensure all BMEC staff can identify a deteriorating patient; and that this is recorded in a structured way in order to monitor the effectiveness of this.
- BMEC service work towards minimising cancelled procedures due to lack of patient records.
- BMEC staff to be fully aware of when patients may require a deprivation of liberty safeguard (DOLS) application in order to ensure patients that lack capacity to consent to treatment is provided with appropriate care.

Children's and Young People BMEC:

- That a strategy for services for children and young people is developed and embedded, and there is improved reporting about service plans and priorities.
- Review the arrangements for data collection that is specific to children and young people such as the audit plan and reporting, training and development records.
- Greater visibility and support of the children and young people service from the executive leadership team.

End Of Life care:

- The service must ensure they are preventing, detecting and controlling the spread of infections, including those that are health care associated in the mortuary department.
- The trust should ensure they have updated 'Anticipatory Medication Guidelines'. We could not be assured staff were following the most up-to-date guidelines.

Outpatient Department including BMEC:

- Staff working in the outpatients department have their competencies checked regularly and that this is evidenced.
- Ensure that staff receive training to improve awareness of who the trust safeguarding leads are.
- The layout of the consulting rooms in the BMEC orthoptics department did not always ensure patient's privacy and dignity were protected.

Summary of findings

- Ensure all incidents are reported including those involving patient falls on the escalator in the Birmingham Treatment Centre.
- Patients in the BMEC outpatients waiting area are kept informed of waiting times and late-running clinics.
- Reassess the layout of the BMEC coffee shop seating area to ensure people can move about safely, and sufficient space is provided for people using wheelchairs.
- All staff have annual appraisals.
- There are chaperone notices in the outpatient's department.
- There is clear signage in the outpatient's department.
- Staff complete training to raise awareness and improve skills for working with people with learning disabilities.

Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated ED as requires improvement because: • The overall quality of patient notes at City Hospital ED was variable, with adult notes being less consistent. Patient records at BMEC ED did not meet standards for general medical record keeping by physicians in hospital practice • Staff told us that the rotation of staff between sites was not liked and that they were not comfortable when working at the Sandwell hospital. • Between December 2015 and November 2016, the trust's unplanned re-attendance across both sites was worse than the England average. • Information for the trust from February 2017 shows that 82% of patients spent less than 4 hours in the ED, which is below the national average of 85.5%. • There was a lack of consistent management across the two main sites. However, • Staff told us that they were encouraged to report incidents and the incident reporting culture had improved at City ED from the last inspection in 2014. • We found that the system for storing and controlling medicines in City Hospital ED had improved since the last inspection. • We saw patients being cared for with compassion and staff were considerate to patient needs. • Multi-disciplinary team worked well together. Medical and nursing staff worked well with each other and communication with other specialities was good. • The children's ED was adjacent to the main ED and separated visually and audibly to ensure better privacy and safety. • Local leadership was good and we saw the manager available to staff for support.

Summary of findings

- The paediatric emergency medicine (PEM) consultant was creating learning opportunities for staff, introducing a consistent approach to work within children's' ED.
- We saw a good culture of hand washing and using hand sanitising gel. Staff and visitors were observed using the hand sanitising gel appropriately.

Medical care (including older people's care)

Requires improvement

We rated medical care as Requires Improvement because:

- Medical services were one of the areas of most concern at the trust and had been so for the past two years. Although there had been significant improvements across this service since the last inspection, progress was slow.
- We found a range of concerns in relation to the safety of care including the prescribing of medicines and low staff attendance at some mandatory training such as basic life support training.
- There was limited learning from incidents and safety concerns were not always addressed promptly. We found this in relation to infection prevention and control, the contents of emergency resuscitation trolleys and the management of patients living with dementia.
- There was inconsistency in the application of the Mental Capacity Act (2005) when people were unable to make some decisions for themselves. Decisions about people's care had been made without evidence of mental capacity assessments being completed or evidence of how decisions were made in their best interests. Deprivation of Liberty Safeguard (DoLS) applications which are required to provide authorisation for a person's freedom to be restricted to maintain their safety, did not always contain the information required to ensure the safeguards were being applied appropriately and in the person's best interests.
- There were variations in the quality of management and leadership, leading to a lack of consistency in care processes and which impacted on the effectiveness and responsiveness of care.

Summary of findings

- Delays occurred at most stages of the patient journey from admission to discharge.

However:

- The service took account of the needs of vulnerable patient groups including those with a learning disability and those who were unable to speak English. Adaptations had been made to the environment to better meet the needs of patients living with dementia and an activities coordinator provided therapeutic activities for those living with dementia or with delirium and those without outside contacts.
- The outcomes for patients undergoing care for specific medical conditions were measured and compared with other trusts through participation in national clinical audits. The outcomes for patients with heart failure and following heart attacks were in line with or better than the national average.
- There were some improvements in key performance indicators relating to the quality and safety of care. Managers were aware of the issues in relation to the consistency of care and an improvement programme to reduce delays in the patient journey from admission to discharge was underway.

Surgery

Good

We rated surgery services as Good because:

- The trust held 10 quality improvement half days (QIHD) per year during which time staff shared learning and attended relevant training.
- Robust application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist was visually monitored on a daily basis.
- Staff were aware of Duty of Candour and their role when things went wrong; they had an understanding of the Mental Capacity Act 2005.
- Staff were seen adhering to the infection control policy of arms bare below the elbow. The use of hand sanitiser and protective clothing policy was also adhered to.
- Theatres and the wards were clean and tidy; cleaning schedules were dated, signed and displayed.

Summary of findings

- Medication refrigerators temperatures were recorded daily and medication cupboards were locked.
- We saw that patients' medical records were secure in all areas.
- Staff were aware of how to report safeguarding concerns and what to look for when caring for patients.
- Mandatory training and appraisal rates were variable but on target to be met.
- A dependency 'acuity tool' was used to assess the staffing numbers required.
- Bank and agency staff filled nursing staff vacancies.
- Medical staffing was stable and locum cover was arranged as required.
- Venous Thromboembolism(VTE) assessments were completed in line with national guidance and individual risk assessments were completed and audited.
- Pre-operative assessments were completed to ensure patients were safe for surgery.
- Multidisciplinary teams worked well together.
- Staff were seen attending to call bells promptly.
- Patients we spoke with told us they had received good cared from friendly staff. They were satisfied that their pain control had been managed well.
- The average length of stay was below the England average for elective and non-elective surgery
- Submission to the National 'bowel cancer audit' performance was recorded as 100% in 2016.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery, was slightly above the England average, for overall performance since January 2016.
- Local senior leadership was supportive and visible.
- Patients and local people were encouraged to get involved in the hospital.

However:

- Never Events had been reported, however robust measures had been taken to ensure patients safety in the future.

Summary of findings

- Safety thermometer information was recorded but not displayed on the wards.
- Staff did not hear about other wards complaints so wider learning was not shared.
- Staff felt listened to when they raised issues, but were less positive about the follow up action taken. Staff felt they were not being included in plans for surgical services.

Services for children and young people

Requires improvement

We rated this service as Requires Improvement because;

- Children's and young peoples' services were delivered in a predominantly adult environment. There were no separate children and young people waiting areas, designated play areas, or children's toilets in the day surgery unit (DSU) emergency department, or outpatients' department.
- **Staff, including the leadership team, were unclear about the immediate plans, strategy, and priorities for the children and young people service.**
- Staff told us they would like to see greater recognition and support of the children and young people service from the executive leadership team. They described a lack of formal interaction with the trust board. Staff felt the executive team had not been visible and could not recall when they had last visited the service. However, staff told us there had been some recent improvement with increased engagement with medical staff, particularly consultants.
- **Medical staffing levels fell below national standards, particularly consultant staffing. There was no seven day cover from a consultant paediatrician and no agreed plans to increase the number of paediatric ophthalmology consultants.**
- **There is a risk that children, particularly those younger than three years of age, who attend the emergency department at the Birmingham Midland Eye Centre with an emergency eye**

Summary of findings

condition, do not receive either timely or appropriate treatment due to limited availability of specialist medical staff and anaesthetists.

- There was no separate storage of adult and children and young people emergency medicines and equipment.
- Surgical lists for children and young people were scheduled on Mondays and Thursdays only. The non-surgical service did not run at evenings or weekends, which reduced accessibility.
- There was no evidence to demonstrate that staff had completed paediatric life support training, with the exception of three children's trained nurses and one paediatric anaesthetist we spoke with. The leadership team identified their highest risk was there was no guarantee there would be a paediatric anaesthetist available for out of hours cases, or emergency cases, or for days when elective surgery was not taking place.
- Children and young people friends and family test results, were not reported separately, this meant that there was limited opportunity to act on patient feedback to improve or change the service.
- In the Birmingham Midland Eye Centre emergency department, we saw people overheard consultations with other patients due to the open plan layout.
- Risks to the service were not always mitigated or acted upon in a timely manner and largely remained unresolved.
- The trust did not provide or report on separate mandatory training for the children and young people's service as it was part of the (adult) ophthalmology service within the surgical directorate. This has therefore been reported in the surgery, core service report.

However,

- Nursing staffing levels in the DSU met the Royal College of Nursing (2013) Standards for Staffing Levels in Children and Young People's Services.

Summary of findings

- The environment was clean, infection rates were low, and staff complied with infection prevention and control practices including hand hygiene and arms bare below the elbow.
- The service had effective systems in place to ensure the safe supply, storage and administration of medicines.
- Records were securely stored and maintained in in accordance with national and local standards.
- Staff used an age specific paediatric early warning system (PEWS) to observe for clinical deterioration and appropriate action was taken as a result of the findings.
- In the operating theatre, there was a dedicated recovery area for children and young people separated by screens from the area used by adults.
- A recently introduced one stop pre-operative clinic helped to reduce the number of hospital appointments patients needed to attend.
- Extended role training was underway to manage a range of new and follow up patients in allied health professional led clinics. This was designed to deal with the high volume of patients.
- There was access to a multi professional health care team within Birmingham Midland Eye Centre who worked collaboratively to understand and meet the range and complexity of children and young people's needs.
- Interactions between staff and patients were individualised, caring and compassionate and children and young people and parents felt they were treated with dignity and respect.
- Staff understood the trust safeguarding policy and had access to a named safeguarding lead nurse. Staff were provided with mandatory safeguarding training at a level appropriate to their job role.
- Parents were involved in their child's care and treatment. We saw staff spoke with children and young people in a way that enabled them to gain a full understanding of their treatment plan and take an active role in decision making.
- Staff told us nursing and orthoptist leaders were supportive, visible and accessible.

- The orthoptist team had introduced a formalised audit programme, and were working towards the introduction of allied health professional led clinics.
- Staff attended monthly quality improvement half days, which addressed areas that required improvement, and encouraged reflection on how clinical delivery could be improved.
- During our inspection, staff told us they felt there had been some improvements in engagement between medical consultants and the executive management team within the previous month, since the new team had taken up post.

End of life care

Outstanding 

We rated End of Life Care as outstanding because:

- The palliative and end of life care service was tailored to meet the needs of end of life patients. Advice was managed and timely to take into account patient's individual needs, including for patients with urgent needs.
- The palliative and end of life care service worked together with commissioners and other providers to plan new ways of meeting people's needs. The service had a strong focus on innovative approaches of providing integrated care pathways, particularly for patients with complex or multiple needs.
- Patient admission, discharge and moving patients between hospital care and care in the community followed models of best practice in integrated, person-centred care.
- The palliative and end of life care service designed services to meet the needs of the local community to enable all people to access palliative and end of life care services.
- Patients had seamless access to palliative and end of life care, support and advice 24 hours a day, seven days a week.
- Experienced staff provided a compassionate and responsive evidence based service for end of life care patients.

Summary of findings

- Incidents for the palliative and end of life care service were low. Staff were knowledgeable about the trust's incident reporting process. We saw concerns were investigated thoroughly and learning widely shared.
- The service had one single point of access for patients and health professionals to coordinate end of life care services for patients.
- The palliative and end of life care service was well developed across the trust and held in high regard by all of the wards we visited.
- End of life and palliative care was a priority for the trust. The service was well developed, staffed and managed as part of the iCares directorate within the Community & Therapies clinical group.
- There was a clear governance structure from ward and department level up to board level.
- Good governance was a high priority for the service and was monitored at regular governance meetings.
- Staff were proud of their service, and spoke highly about their roles and responsibilities, to provide high levels of care to end of life patients.
- We saw this often exceeded patient's medical needs. We were told of numerous examples where the staff had gone the extra mile. This included arranging a wedding for a person in their last few days of their life to marry their long term partner. Staff had decorated the ward to make the event as special as possible.
- Advanced care plans and specialised care plans were used across the trust for end of life patients. They were used as a person centred individual care record to include all the needs and wishes of a patient and their family.
- The trust used a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form. The trust DNACPR was easily identifiable with a red border and was stored at the front of the patient notes. We saw all DNACPR forms were completed accurately on the wards. This was much improved from concerns raised during our last CQC inspection in October 2014.

Summary of findings

However;

- We saw mortuary staff were not following the trust's infection control policy. We were not assured the service was protecting mortuary staff and the general public that visited the mortuary from potential health and infection risks.
- Mandatory training for mortuary staff did not include infection control training.

Outpatients and diagnostic imaging

Good

We rated this service as good because:

- We saw that staff reported the majority incidents of all levels and staff we spoke with were clear of the policies and procedures around this.
- We saw that all areas were visibly clean and tidy and that there were processes in place to ensure these standards were maintained.
- We saw that equipment was risk assessed and tested to ensure all risks were minimised
- We saw examples of positive multi-disciplinary working and staff told us this was consistently good across the trust.
- Policies and guidelines used were up to date, relevant and staff had access to them.
- In the imaging department, local Diagnostic Reference Levels (DRLs) had been established, were reviewed regularly and reduced by the medical physics service whenever possible. We saw evidence that DRLs were discussed in IRMER committee meetings and we saw that mostly these were better than the national average.
- We saw staff fully explain the process for assessment, examination and diagnosis and treatment in a clear way for the patient to understand. Patients we spoke with told us they had felt fully involved throughout their consultations and treatment.
- We saw examples of innovation that would improve patient experience.
- Extra clinics took place throughout the day and during the evenings to meet the demand of services and to reduce waiting times for patients.
- The BMEC waiting area and processes for appointments had certain adaptions in place to

Summary of findings

meet the needs of patients using this specialist building. This included colour coded waiting areas, one-stop clinics, induction loops for the hearing impaired and a designated car park.

- Staff told us that their local managers were supportive and worked with them towards improving care for patients. All of the staff we spoke with told us they felt they could raise issues with senior staff if they needed to.

However:

- From April 2016 to March 2017, one 'never event' had been recorded at BMEC.
- We saw that some rooms containing sharps bins were left unlocked and were therefore accessible for the public. We also saw some items that should have been stored under the Control of Substances Hazardous to Health (COSHH) were in unlocked cupboards.
- Resuscitation trolleys were left open in patient areas and did not have tamperproof tags.
- Staff told us about frequent incidents involving the escalator in the Birmingham Treatment Centre. The data provided did not reflect the amount of incidents that the staff told us occurred, therefore we had concerns that not all incidents were reported with regards to the escalator.
- We saw that patient records were at times left on trolleys or desks unattended. This meant that staff were not always protecting patient confidentiality.
- Staff in the outpatients department did not have their competencies regularly assessed to ensure they were confident and competent to carry out their role.
- The layout of the consulting rooms in the BMEC orthoptics department did not always ensure patient's privacy and dignity were protected.
- There were no chaperone notices in any of the outpatient areas.
- Staff told us that clinics often went over the scheduled time and patients could therefore be waiting longer than expected.
- There had been a workforce review of staffing for the service across all OPD services, which had led

Summary of findings

to significant changes in the two years prior to the inspection. Staff told us they had not felt part of this and that they felt unaware of the strategy for the future of the service.

City Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Services for children and young people at BMEC; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to City Hospital

City hospital was first built in 1889 as an extension to the Birmingham Union Workhouse. It originally comprised a single corridor stretching for a quarter of a mile with nine Nightingale ward blocks radiating from it along its length. City Hospital (formerly Dudley Road Hospital, and still commonly referred to as such) is a major hospital in the city of Birmingham, England. It is located in the Winson Green area of the west of the city.

The Birmingham Treatment Centre opened on the City Hospital site in November 2005. It includes an Ambulatory Surgical Unit with six theatres and extensive imaging facilities. The City site also includes the Birmingham and Midland Eye Centre that we have included to this report.

In October 1823, a British eye surgeon, started his campaign to open an eye hospital in Birmingham, in April 1824, The Infirmary for the Cure of Diseases of the Eye was opened at Cannon Street, Birmingham. After 30 years, the increase in work at the infirmary meant a larger hospital was needed, to accommodate a house was bought in Steelhouse Lane and converted into a 15-bedded hospital known as the Birmingham and Midland Eye Institution. After 112 years, the hospital moved to its present location on Dudley Road and was renamed as the Birmingham and Midland Eye Centre (BMEC). BMEC includes an accident and emergency department, outpatient suites, four operating theatres, ophthalmic imaging, visual function department, optometry department, orthoptic department, day surgery unit, an ophthalmic in-patient ward and an Academic Unit of the University of Birmingham.

HRH Prince Andrew officially opened the Birmingham and Midland Eye Centre on Friday, 28th June 1996. BMEC is currently one of the largest eye centres in Europe.

Our inspection team

Our inspection team was led by:

Team Leader:

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

The team included 21 CQC inspectors, 34 specialist advisors to include Consultants, Doctors, Matrons, Nurses, Midwives, Therapist, and one ‘experts by experience’. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

CQC analysts, planners, and recorders also supported the inspection team.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew.

We carried out an unannounced visit on 16 February concentrating solely on the medicine core service, follow with a focussed short notice announced visit covering five core services this took place on 28 to 30 March 2017 and unannounced visits on 6, 11, 12, and 13 of April 2017.

We concentrated on the following six core services:

- Urgent & emergency services including BMEC
- Medical care (including older people's care)
- Surgery including BMEC
- Outpatient and Diagnostic Imaging including BMEC
- End of life care
- Children and Young People service at BMEC

To get to the heart of people who use services' experience 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?

We met with the trust executive team both collectively and on an individual basis, we also met with service managers, leaders, and clinical staff of all grades.

During the visit we held focus groups and interviews with a range of staff who worked within the service, such as, palliative care nurse specialists, district nurses, nurses, healthcare assistants and senior clinicians.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

Facts and data about City Hospital

The annual turnover (total income) for the trust was £436 million in 2015/16.

Sandwell and West Birmingham NHS hospitals serve a population size of 530,000 across West Birmingham and six towns within Sandwell. The trust employs approximately 7,500 staff who work across acute and community services.

The health of people in Birmingham is generally worse than the England average. Birmingham is one of the 20% most deprived districts/unitary authorities in England, and about 29% (72,000) of children live in low-income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 8.3 years lower for men and 5.9 years lower for women in the most deprived areas of Birmingham.

City hospital has 14 wards and 2-community inpatient wards total of 304 beds. During December 2015 to November 2016 trust had, 102,151 of patient were admitted to the trust as inpatient. 1.014,513 people attended outpatient clinics. 234,359 attended both emergency departments.

During April 2016 and December 2016 BMEC had 75,157 patients who attended outpatient clinics, 5,130 patients were seen in surgery, this included inpatient, day cases, and emergency cases. 17,465 attended the emergency department in the opening hours of 9-5.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
End of life care	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

There are two Emergency departments operating from City Hospital, one from the main hospital site and a second from Birmingham Midland Eye Centre (BMEC). We have reported on them separately under each domain.

For City Hospital Emergency Department

As part of Sandwell and West Birmingham Hospitals Trust, City Hospital, Birmingham, provides a 24-hour emergency and urgent care to the diverse local population. It has a separate entrance from the main hospital and Birmingham and Midland Eye Centre (BMEC).

The department offers early assessment and treatment for stroke patients', with the ability to stabilise, resuscitate and treat extremely ill or injured. Priority is given to stroke and heart attack patients, along with young children.

The hospital was last inspected in 2014 at which time urgent and emergency care services were rated as 'requires improvement' in the safe, responsive and well led domains and good in effective and caring domains. We have seen improvements in some areas from the last inspection.

The adult emergency departments saw 234,141 patients between January 2016 and December 2016. The paediatric emergency departments were responsible for seeing approximately 46822 children during the same period.

We visited the emergency department over three days and at different times, which included an unannounced visit on 12 April 2017. During the inspection, we spoke with 28 members of staff, including doctors, nurses, healthcare assistants, managers and consultants. We spoke with 12 patients and 4 family members and examined 42 sets of patient notes.

A GP surgery runs from the ED at City hospital. A nurse assesses patients upon arrival and directs them either to the ED or to the GP services to be treated. This service works alongside the ED and provides an alternative treatment pathway from the emergency department.

For Birmingham and Midland Eye Centre (BMEC) Emergency Department

Birmingham and Midland Eye Centre (BMEC) is one of the largest centres of its kind in Europe. Based at City Hospital in Birmingham, the facility receives referrals from hospitals and GPs across the region.

The Eye Emergency Department (ED) at BMEC provides an emergency service for adults and children with acute sight threatening eye diseases and eye injuries. The Urgent Care Clinic provides a service for adult patients with less urgent eye conditions.

The BMEC ED was open to the public, Monday to Friday 8.30am to 7pm (although the department was open until 9pm to allow doctors and nurses to see and treat patients who arrived after 7pm). The department was open at 9am to 7pm on Saturdays and 9am to 6pm on Sundays. Outside of these times, staff could see patients at City Hospital's ED, where management provided facilities to assess and treat patients with eye problems.

Urgent and emergency services

During our inspection we visited the adult and children's emergency department at the Birmingham and Midland Eye Centre. We observed how staff cared for patients and spoke with seven patients who used the service. We looked at 16 sets of patient's personal care and treatment records, and reviewed documentation provided by the trust including performance information.

We also spoke with 38 members of staff including the executive and clinical leadership team, ophthalmology consultants, nurses, health care assistants, orthoptists, the eye clinic liaison officer and administrative staff.

Summary of findings

We rated this service as requires improvement because:

- The overall quality of patient notes at City Hospital ED was variable, with adult notes being less consistent. Patient records at BMEC ED did not meet standards for general medical record keeping by physicians in hospital practice.
- Staff told us that the rotation of staff between sites was not liked and that they were not comfortable when working at the Sandwell hospital.
- Between December 2015 and November 2016, the trust's unplanned re-attendance across both sites was worse than the England average.
- Information for the trust from February 2017 shows that 82% of patients spent less than 4 hours in the ED, which is below the national average of 85.5%. Results for January 2016 show 91% indicating a decrease over the 12-month period.
- There was a lack of consistent management across the two main sites. We spoke to staff from Sandwell hospital that were at City hospital on rotation and were told that the environment was better at City hospital.

However:

- Staff told us that they were encouraged to report incidents and the incident reporting culture had improved at City Ed from the last inspection in 2014. This was the first inspection for BMEC ED.
- We found that the system for storing and controlling medicines in City Hospital ED had improved since the last inspection in 2014.
- Multi-disciplinary team worked well together. Medical and nursing staff worked well with each other and communication with other specialities was good.
- We saw patients being cared for with compassion and staff were considerate to patient needs.
- The children's ED was adjacent to the main ED and separated visually and audibly to ensure better privacy and safety.
- Local leadership was good and we saw the manager available to staff for support.

Urgent and emergency services

- The paediatric emergency medicine (PEM) consultant was creating learning opportunities for staff, introducing a consistent approach to work within children's' ED.
- We saw a good culture of hand washing and using hand sanitising gel. Staff and visitors were observed using the hand sanitising gel appropriately.
- The hospital has a good facility to isolate and decontaminate anyone arriving at the ED, if required.

Are urgent and emergency services safe?

Requires improvement

For City Hospital Emergency Department and Birmingham and Midland Eye Centre (BMEC) Emergency Department.

We rated safe as requires improvement because:

- At City Hospital ED, we looked at 42 sets of patient notes, which included 11 children's. The overall quality of entries was variable, with adult notes being less consistent. There were instances where analgesia had not been recorded as assessed or administered and where blood glucose monitoring (BM) had not been done.
- We saw that waiting times were not displayed for patients or visitors, within this area. Staff told us that they would regularly tell patients if there was a long wait expected. There were inadequate facilities for paediatric patients attending BMEC ED.
- There was a risk that children, particularly those younger than three years of age, who attended the emergency department at the BMEC ED, did not receive either timely or appropriate treatment due to limited availability of specialist medical staff and anaesthetists.
- There was no separate storage of adult and children and young people emergency medicines and equipment.
- Storage of fluids at BMEC was not tamper proof in line with resuscitation council guidelines.
- Patient records did not meet standards for general medical record keeping by physicians in hospital practice**.**
- We found BMEC prescription pads left on desks in open and accessible areas.

However:

- Staff in the main ED, told us that they were encouraged to report incidents and the incident reporting culture had improved from the last inspection in 2014.
- We saw a good culture of hand washing and using hand sanitising gel. Staff and visitors were observed using the hand sanitising gel appropriately.
- We found that the system for storing and controlling medicines had improved since the last inspection in 2014.

- The hospital has a good facility to isolate and decontaminate anyone arriving at the ED, if required.

Incidents

For City Hospital Emergency Department

- The trust reported no 'never events' in the emergency department (ED) from February 2016 to January 2017. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There was one serious incident (SI) recorded for the period between February 2016 and January 2017, which related to a fall.
- We saw ED had their Safety thermometer information on display; this was published on a monthly basis. There were no pressure ulcers but two catheter urinary tract infections (UTI's) recorded in ED across the trust, between January 2016 and January 2017.
- The hospital used an electronic incident reporting system. All staff that we spoke to had knowledge of how to report incidents and demonstrated the process to inspectors.
- Staff told us that they were encouraged to report incidents and the incident reporting culture had improved from the last inspection. Learning from incidents was shared at team meetings and there was a folder available for staff to access information about incidents. We saw information contained within these folders going back 6 months.
- We spoke with a nurse that assisted managers in reviewing incidents as part of their development. The nurse would look at trends, review the quality of the incidents, and escalate any immediate concerns. Concerns would then be communicated at daily hand overs and team meetings.
- There were no black breaches reported between January 2016 and December 2016. A black breach is when handovers from ambulance crews to ED staff take longer than 60 minutes after arrival.
- Mortality and morbidity meetings took place monthly and included deaths that had occurred in emergency department. Information and investigation reports were reviewed to identify if there were areas for improvement. Managers in ED discussed mortality and morbidity incidents during their monthly clinical governance meetings. We saw copies of the minutes of these meetings, which were also made available to staff in the department.
- From November 2014, NHS providers were required to comply with the Duty of Candour (DoC) Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Most staff knew about DoC and could describe the process including the levels of harm. However, two were not familiar with the terminology, but understood the need to be open and honest when incidents occurred.
- Managers informed us that they would routinely feedback to families if an incident had occurred, even if the threshold for duty of candour had not been met.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- BMEC ED reported 12 incidents between 1 October 2016 and 31 December 2016. Two of these related to security, three to slips/trips/falls (patient), one to a fire hazard, two to verbal abuse and aggression, one to assessment, one to documentation and two to information technology. Eleven were classified as near misses, or no harm and one as moderate harm.
- Management at BMEC ED did not attend mortality and morbidity meetings. They told us this was because there were no patient deaths in the department.

Cleanliness, infection control and hygiene

City Hospital Emergency Department

- We saw a good culture of hand washing and using the hand sanitising gel. Staff and visitors were observed using hand gel appropriately. We saw ambulance crews, security staff and police officers using the hand gel when entering and leaving the ED.
- We were told that the doctors had been encouraged to lead on audits to improve awareness around infection, prevention and control (IPC) and this had been beneficial in improving the culture within the ED.

- 96% of staff were compliant within the ED at the time of inspection, which had increased from an audit result of 49% compliant in January 2017.
- We saw signs were on display informing staff and visitors about using hand sanitising gels, all dispensers were in use.
- Housekeeping staff told us that they had received induction training and were aware of policies such as the deep cleaning policy. They told us that they felt safe working in the ED and that managers gave them talks about the safety briefings.
- We saw housekeeping staff cleaning areas within the ED and they told us that they worked to a schedule, which we saw on display. Staff could also request areas to be cleaned for example after a patient moved from an isolation area.
- Audit results from January 2017 showed that ward cleanliness scored 94% and this was consistent for the period up to inspection.
- We saw that the windows above the minors' area were dirty; staff told us that these were not part of the housekeeping schedule and that they had not been cleaned for several months. The matron was informed and we were told that the facilities team would be contacted to clean them.
- All staff we observed were following the arms bare below elbows policy and washing hands or using hand sanitising gel before commencing contact with patients.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- There were no cases of unit-acquired post-operative endophthalmitis in the last year. Endophthalmitis is an inflammation of the interior of the eye. It is a possible complication of all intraocular surgeries, particularly cataract surgery, with possible loss of vision and the eye itself.
- There were no cases of health care associated conjunctivitis adenovirus identified in patients who had a previous visit to the department in the last year. Viralconjunctivitisis a highly contagious acuteconjunctivalinfection usually caused bythe adenovirus.
- Personal protective equipment (PPE), such as gloves, were available in treatment rooms and cubicles. In addition, cubicles and treatment rooms had adequate hand washing facilities.
- Staff could use the paediatric room as an isolation treatment room for patients presenting with cross-infection risks.
- The sharps bins were in good order. For example, staff had closed the opening to the sharps containers in unsupervised areas, to prevent spillage or tampering; none of the containers were more than three quarters full. This was in line with guidance by the Health and Safety Executive.
- As part of the trust's on going initiatives for the reduction and prevention of healthcare associated infections, all clinical areas were required to undertake hand hygiene audits. Compliance with hand hygiene between January 2016 and January 2017 was 100%.

Environment and equipment

City Hospital Emergency Department

- Children were seen separately to adults and had a bespoke area for treatment adjacent to the main ED.
- We found that all bays we checked were visibly clean and tidy. However, some work surfaces had minor damage due to wear and tear.
- The plaster area was visibly clean, but we saw 10 medical gas bottles unsecure in the corridor area. Staff moved them to a suitable place when they were made aware.
- Resuscitation equipment and trolleys had been checked daily as required by trust policy. Equipment was sealed and in date where appropriate and the trolleys were visibly clean and organised.
- The waiting area was visibly clean with fixed seating areas for patients to use.
- We saw that waiting times were not displayed for patients or visitors, within this area. Staff told us that they would regularly tell patients if there was a long wait expected.
- We examined a risk assessment for the mental health consultation room that was situated close to the nurses' station. There had been a ligature point assessment completed and actions defined for when a particularly vulnerable patient was in the room. This included, removing the trolley from inside the room, and ensure the door could be fully opened. The door was a design to open inward and outward to prevent barricading.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- The BMEC ED had a separate emergency only entrance from the rest of the hospital. The reception desk was partitioned into a small 'pre triage' desk and a registration desk. Staff required patients to present to the pre triage desk upon arrival, however the registration desk was the first desk the patient came across upon entering the building. This resulted in patients queuing for the registrations desk only for the reception staff then instructs them to report to the pre triage desk next door.
- The reception was in the urgent care waiting room section of the ED. Patients who had been directed by staff to the ED service sat in a separate waiting area.
- There were inadequate facilities for paediatric patients attending BMEC ED. The Royal College of Paediatrics and Child Health's 'Standards for Children and Young People in Emergency Care Settings' 2012 states that children should be provided with waiting and treatment areas that are audio-visually separated from the potential stress caused by adult patients. The document also states children's areas should be monitored securely and zoned off, to protect children from harm, and access should be controlled. There was no separate paediatric waiting area inn BMEC ED
- We saw adults and children waiting in the same area during our inspection. Managers told us this was due to physical capacity limitations.
- The paediatric waiting area was a very small area allocated in the corner of the main waiting room. We saw children playing on the floor, however there was no soft protective flooring provided. Management had identified this on the risk register. The action plan was to complete an in depth audit of paediatric attendances, training of staff to provide new clinical pathways for children and to provide an improved flow for children away from ED.
- There was only one consultation room in the emergency department which management had allocated for children and young people. Therefore, if two children presented at the same time or staff were using the room as an isolation room, there was a risk that staff may not see and treat children in an appropriate paediatric environment. Staff told us that they tried to mitigate this risk by scheduling appointments to ensure that staff were not using other consulting rooms.
- We saw a supply cage and portable screen blocking the fire exit. We escalated this to the department manager who immediately removed them.
- Staff combined the resuscitation trolley for adults and paediatric patients. We found storage of fluids was not tamper proof in line with resuscitation council guidelines.
- The patient led assessment of the care environment (PLACE) score for condition, appearance and maintenance was 91% compared to a national average of 93%.
- The first user of the day calibrated the tono-pen. Staff were not permitted to use the tono-pen until it had been calibrated. Thetono-penis a handheld device that provides a digital readout of eye pressure.
- We were told the glucometer was calibrated daily, however these checks were not recorded, therefore we had no evidence to confirm this.

Medicines

City Hospital Emergency Department

- We found that the system for storing and controlling medicines had improved since the last inspection. All medicines in ED were stored safely in restricted areas, which were only accessible to appropriate staff. An electronic key system had been introduced which had improved the security of medicines.
- A system was in place in the minor's area, to monitor fridge temperature electronically with a warning activated if there were changes detected. The matron had access to print off daily temperatures as an audit check.
- Other fridges used for drug storage were checked daily and signed for. We looked at three months of checks and found all but 5 days were signed for. There were 3 days in February and two in March that were not completed appropriately.
- Staff reported incidents on the trust's reporting system. Learning from incidents was discussed at a medicines safety group and communicated to staff at team meetings.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Medicines used for resuscitation and other medical emergencies were available and accessible for immediate use. However, guidance from the

Resuscitation Council (November 2016) was not always being followed. There was no robust arrangement in place to ensure that medicines for resuscitation were protected from tampering.

- The nurse in charge held keys to the controlled drugs (CD) cupboards. Staff audited controlled drugs on a daily basis.
- All registered nurse prescribers had completed the prescribing practice and formulary for non-medical prescribers.
- The pharmacy department at BMEC was located on the ground floor next to the ED. The pharmacy department was situated near the front of the hospital but was very small in relation to the demands of the service. Pharmacy staff appeared to work well within the small space and made the best use of all available areas.
- The waiting area for patients outside the pharmacy did not protect patients privacy due to the fact that there was nowhere for patients to wait apart from by the pharmacy hatch.
- The pharmacy dispensed prescriptions for the ED. They only dispensed hospital prescriptions that were marked as ''this prescription can only be dispensed at the Pharmacy Departments of Sandwell and West Birmingham Hospitals NHS Trust.''Patients were required to take other prescriptions to a retail pharmacy. The pharmacy was open Monday to Friday: 9.00 -13.00 and 14.00 -16.45. Patients could attend the pharmacy at city hospital between 13.00 and 14.00 if they could not wait for the BMEC pharmacy to re-open after the lunch break.
- We found BMEC prescription pads left on desks in open and accessible areas. Management told us this was acceptable practice as they were specific to BMEC ED and patients could not use them elsewhere. However, the NHS-Security of prescription forms guidance (August 2015) states "Prescribers are responsible for the security of prescription forms once issued to them, and should ensure they are securely locked away when not in use".
- A Medicine Optimisation policy dated January 2016 detailed arrangements for prescribing, requisition, storage, administration, and control of medicines. The trust had shared this on the trust intranet to enable staff to have direct access to the policy.
- BMEC ED did not carry out medicine audits, however managers told us that all non-medical prescribers practice were audited annually. Managers did not provide us with evidence of these audits.

Records

City Hospital Emergency Department

- We looked at 42 sets of patient notes, which included 11 children. The overall quality of entries was variable, with adult notes being less consistent. There were instances where analgesia had not been recorded, assessed or administered and where blood glucose monitoring (BM) had not been done. The children's notes also had inconsistencies around analgesia but were good in safeguarding assessments, which had been completed for every set.
- Patients were assessed using a nationally recognised early warning score (NEWS) to ensure the correct treatment and care was provided. We saw examples of these assessments in all patient records that we checked.
- Children had been assessed and their paediatric early warning score (PEWS) was noted at the time of triage and within 15 minutes of arrival at ED. We saw evidence of this in the 11 patient notes that were checked.
- VitalPAC was introduced into SWBH in March 2014 and had been implemented, but is now not in use in the ED, across both sites. VitalPAC is a mobile software information system for monitoring the vital signs of adults, including pregnant women and children in hospital. Using manually entered or automatically captured vital sign data, it is designed to identify deterioration in their condition and alert clinical staff.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- BMEC ED was working towards a paper light clinical environment in line with the trust's strategy. To support this move, the trust had invested in an electronic patient record system.
- We reviewed 16 sets of records in total. These included nursing, medical and triage records
- Five sets of records were urgent care patient records, 11 sets were ED and two of these records were children's notes.
- Staff recorded patient's notes on two systems, an electronic patient record system, which holds all patients clinical, and health information in one place and a system, which held electronic medical records for ophthalmology specifically.

- It was possible to track the patient's journey through the records as staff recorded key times, including time of arrival, triage time and time of discharge.
- Patients were pre-triaged first and then 'registered' at the reception desk where biographical data was recorded and information checked such GP and address details.
- Some records, triage records, management plan/ comments and outcomes were not fully completed and therefore not in line with guidance from regulatory bodies.
- Doctors and nurses had not always recorded designations, time seen and GMC/NMC numbers.
- Staff had not always comprehensively recorded assessments. For example, elderly patients did not always have social history or safeguarding information recorded.
- The two sets of children's notes we reviewed were sparse and lacking in safeguarding information.
- Staff rarely recorded vital sign observations, although there were vital sign fields for staff to complete. On one patient's notes a doctor had recorded "BP normal, not known to be low", however, there was no evidence in the records that the doctor had checked the patient's blood pressure to confirm this.
- Staff recorded medications correctly in the majority of the records checked.
- The medical content of the notes were of a good quality.
- There were a large number of abbreviations used by both medical and nursing staff. For example, RAPD (relative afferent pupillary defect). This is not in keeping with NHS Professionals CG2 – Record Keeping Guidelines guidance. Which states abbreviations should not be used in medical notes
- We were only able to review one prescription chart. Staff had completed this correctly and the medication administered was as prescribed.
- The audit of paper healthcare records was included as a clinical audit in the trust's clinical audit plan. The audit aimed to examine the content and quality of information that was documented by clinicians in the healthcare record, measure compliance with the quality standards contained in the policy for the 'Management of Healthcare Records' (ORG/018) and to raise awareness of the importance of 'good' record keeping by ensuring clinicians were actively involved in the audit process.
- Key performance indicators included legibility and notes were dated signed and written in black ink. Ophthalmology completed 157 audits of notes in total. They achieved 97% for folders being in a satisfactory condition, 8% for basics of record keeping, 83% for contemporaneous notes, 1% for self-inking ID stamp used and 0% for allergies recorded on prescription sheets. We did not have the data for BMEC ED specifically.

Safeguarding

City Hospital Emergency Department

- There was a safeguarding policy available to staff electronically and a paper copy was kept in the manager's office. A safeguarding lead nurse was available in the ED at various times during the week and staff we spoke with knew how to contact them at any time.
- Staff knew the procedure for identifying and processing children and vulnerable people to ensure their safety whilst in the ED. They told us they had been trained in safeguarding for adults and children and young people.
- Staff working in hospitals should be safeguarding trained to an agreed level. The competencies for health care staff intercollegiate document (2014) states that clinical staff who contribute to assessing, planning and evaluating the needs of the child or young person should be trained to level 3. In addition, the trust is required to train all staff to an appropriate level for safeguarding adults.
- Training records showed that on average 92% of all staff were trained to level 1, which included administration staff, in safeguarding children. There were 74% of nurses and 32% of doctors trained to level 2 and 79% of nurses and 34% of doctors at level 3.
- For safeguarding adults, there was an average of 92% of all staff, including administration staff, trained to level 1. There were 73% of nurses and 43% of doctors trained to level 2.
- Staff used a flagging system to highlight concerns in the patient record and passed the information to the safeguarding lead nurse or the shift coordinator.
- There were guidelines available to staff and they were able to look for signs of female genital mutilation (FGM) and child sex exploitation whilst reviewing a patient.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- There were appropriate systems and processes in place for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- All of the staff we spoke with demonstrated good awareness of child protection issues. For example, a member of the administration team told us of the action they would take if an adult attended the department who was under the influence of alcohol or who behaved inappropriately and had a child with them. This action was proportionate and met the hospital's safeguarding policy.
- Staff were required to complete a child protection assessment for every child who presented in the department for the first time. They used this process to identify children with concerns such as unexplained injuries. However, staff had not always comprehensively recorded assessments, including safeguarding information.
- We saw information on details of the safeguarding team on the staff notice board.
- All of the staff working in the ED department had completed their safeguarding children and safeguarding adults training to level 1 and 2. We were unable to specify how many were trained to level 3 because the A&E staff who work with children only were allocated to other directorates and were not part of that grouping. Due to the way the trusts HR system was classified we were unable to identify BMEC Children's A&E staff specifically. The safeguarding children and young people: roles competencies for health care staff intercollegiate document (2014) states that clinical staff who contribute to assessing, planning and evaluating the needs of the child or young person should be trained to level 3.The manager responded "Our process is that all have level 2 and providing there is someone on shift who they can discuss concerns with then this is adequate. As such some of our specialist nurses have Level 3 training".
- We reviewed a chaperone policy. This policy set out guidance for the use of chaperones and procedures for clinical consultations, clinical examinations, investigations and clinical interventions, particularly in relation to intimate procedures.

Mandatory training

City Hospital Emergency Department

- Local mandatory training compliance was at 91% at the time of inspection. We saw the data was available on the electronic report and this information had been displayed in the ED for staff to see.
- The trust target for training compliance was 95%, data provided by the trust from December 2016, showed average overall compliance for mandatory training was 91% for nurses, 59% for doctors and 76% for other grades of staff in the ED.
- Bank staff told us that they had access to any training that was appropriate for them. The bank office managed mandatory training but additional training was accessible on request. Mandatory training included infection prevention & control, fire safety, conflict resolution, health & safety, information governance, basic life support, safeguarding and moving & handling patients and heavy equipment.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- The trust target for mandatory training was 95%. This target was set in October 2016, therefore the trust had until October 2017 to achieve this target.
- As of 7 March 2017 BMEC ED had achieved 93% compliance overall. All nursing staff had completed conflict resolution initial training, equality and diversity, harassment and bullying, health and safety, access to health records, introduction to information governance and medical devices competency form. 99% of staff had completed their medical devices training.
- The department were working towards achieving 95 % compliance with the modules conflict resolution update (77%), fire safety workplace (89%), ,Infection control (78 %), information governance refresher (67%), medical devices (99%), medicines management (69%), moving and handling patients (94%), resuscitation - basic life support (72%).

Assessing and responding to patient risk

City Hospital Emergency Department

- VitalPAC was introduced into SWBH in March 2014 and had been implemented in several areas, but now not in use in the ED, because of the electronic systems not being able to support its use.

- Staff monitored and recorded early warning scores in line with clinical care pathways, using the National Early Warning Score (NEWS) system. NEWS is a guide used by medical services to determine the degree of illness of a patient. Paediatric early warning score (PEWS) was used for children in the same way.
- We saw that PEWS was completed and included in all 11children's records that we checked.
- There were clear pathways for staff to manage deteriorating patients. For example, we saw a patient on the sepsis pathway and staff had escalated the concern to consultant following specific guidance.
- The Royal College of Emergency Medicine (RCEM) recommend that the time patients should wait from time of arrival to receiving treatment is no more than one hour. Patients are triaged to enable access to the correct treatment and to maintain a flow through the ED.
- A streaming process took place in reception which involved assessment of the patient's needs and then referring them to GP services, on to Minors or Majors department or if appropriate, to other specialist departments
- Patients are seen in order of clinical priority and not in order of attendance. The Manchester Triage System (MTS) was used to assess each patient on entering the department. MTS is a clinical risk management tool used by clinicians in emergency departments to safely manage patient flow when clinical need far exceeds capacity.
- Staff were able to receive information about a patient before they attended the ED. This was made available through the rapid assessment and treatment area and patients could be prioritised or redirected to improve access and care. Staff also had access to information about the numbers of ambulances arriving at other hospitals in the area.
- There was a rapid assessment and treat (RAT) process in place and we observed the area where ambulance staff can take patients for the assessment. We saw good handovers and communication between paramedics and ED staff and decisions were made to treat the patient appropriately.
- Staff in the RAT area was able to take bloods, cannulate and assess patients using the Manchester triage system.
- We randomly checked four patients located in cubicles to assess the length of time in ED. Two had been in for less than four hours and were awaiting discharge. The other two had been in for less than two hours and both were being admitted to wards. All of them had a care plan in place and were able to tell us what was happening to them.
- Patients with suspected stroke were treated according to a stroke pathway with guidance for staff clearly displayed. A process chart was available to assist staff when treating patients with suspected stroke.
- Patient flow was continually monitored and issues escalated through the capacity meetings, held four or five times a day. We saw an example where a patient was transferred, following a capacity meeting, to Sandwell hospital for more appropriate treatment.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- There was a clear triage system in place. Management told us that experienced ophthalmic-trained nurses carried out pre triages, assessed patients, and assigned them to one of two pathways: the urgent care pathway and the accident and emergency pathway. However, we saw that health care assistants had also carried out pre triages.
- Senior staff told us that they only treated patients with ophthalmic diseases at BMEC. However, if a patient presented in the ED seeking treatment for general health problems, or patients who presented with an ophthalmic problem became acutely unwell due to a general health problem, the patient would be assessed by medical and nursing staff, then stabilised where possible and kept under observation while arrangements were made to transfer them via an ambulance to the general emergency department for care and treatment. During our visit, we observed the consultant calling an ambulance for a patient that had suddenly become acutely unwell.
- Staff told us they would only use the national or paediatric early warning scores system for those patients who were going to theatre.
- Two safety huddles took place each day. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical and opportunities understand what is going on with each patient and anticipate future risks to improve patient safety and care
- We asked BMEC ED for evidence of their rapid assessment and treatment (RAT) processes, however they did not provide us with this information.

Urgent and emergency services

Nursing staffing

City Hospital Emergency Department

- Planned staffing levels and actual numbers were displayed within the majors and minors areas. Staffing numbers were at the planned level during the inspection and on one occasion, there were extra staff available to attend training.
- We were told that on occasions a paediatric nurse was not on duty.
- Staffing levels were determined using an approved acuity tool and this decided the planned levels in each area. The nurse in charge would deploy staff in accordance with the levels set but also moved nurses to prioritise the needs of patients. For example, if minors were less busy a nurse would assist with majors.
- There were 73 whole time equivalent (WTE) staff in post at the time of inspection, against a planned level of 84. This consisted of different grade nurses working in the City Hospital ED.
- Sickness levels for nurses in the ED were 4.32% at the time of inspection. Managers monitored sickness levels at regular meetings and redeployed staff where possible. A social media page was accessible to staff specifically to identify shortfalls and volunteers could cover shifts at short notice.
- The trust used bank staff to cover any shortfall in staffing. This meant that the nurses were trained and familiar with the policies and layout of the ED. Agency staff did not work in the department.
- Staff told us that there was a pressure in covering the RAT because since opening there had been no extra staff to cover. The area was covered within existing staffing numbers from the major and minor areas.
- Staffing levels were correct against planned levels on every occasion we visited. This included our unannounced visit when there were two staff members available above the planned level, to take part in training.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- As a consultant led single speciality ophthalmic ED, there, was no specific acuity tool used in the department. Management informally calculated staffing levels.
- One nurse worked on ED. They worked two shifts a week and had level 3 safeguarding children training.
- In addition, there was 24-hour access to senior children's nurses based in the paediatric assessment unit at the main City Hospital site.
- The BMEC matron was also a paediatric-trained nurse and was available face to face or by telephone in core hours. The matron also had responsibility and accountability for managing the team and a general overview of service provision.
- The nurse in charge led a handover with the doctors coming on duty once a day at around 5pm.
- For the period 31 February 2016 to 31 January 2017, the nursing bank / agency turnover rate ranged from 2.7% to 10.1%. The trust target was less than 11% over a year.
- The trust target for nurse sickness rate was 2.5%. The nursing sickness rate for the period 1 January 2016 to 31 December 2016 was 3.2%, therefore BMEC ED did not achieve the trust target.
- The vacancy rate for nursing staff as of 1 February 2016 was 18%.
- BMEC ED employed two senior advanced nurse practitioners, one senior nurse manager, band 6 nurse practitioners, band 5 senior nurses and health care assistants.
- There was always a band 6 nurse or above in charge per shift.

Medical staffing

City Hospital Emergency Department

- Consultants in the urgent and emergency care department of the trust worked across both sites at Sandwell General Hospital and City Hospital Birmingham. At City ED there was a consultant on duty from 8am to 10pm seven days a week, with on call facility from 10pm onwards.
- Medical handovers took place daily at 8am, 4pm, and 10pm. We saw handovers and patient details were discussed in full their discharge status noted. Discharges were graded as red or green and discussed at capacity meetings during the day. A doctor from the ED would attend every capacity meeting.
- The children's ED had a newly appointed paediatric emergency medicine (PEM) consultant that worked between 10 am and 10 pm on some days and 8 am to 3 pm on others. During other times, a consultant was always available in the main ED or on call.
- The PEM ensures the children's ED has specialist support available to them. There has been a review and

updating of several processes to improve patient care. For example, a review of PEWS has ensured the consistency of CRT, BM and pain scores recorded across both sites.
- Sickness levels for all medics at City ED were at 1.92%. A coordinator reviewed rotas on a weekly basis to predict shortfall.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- We asked BMEC- ED for information on how consultants managed doctors' revalidation; however, they did not provide us with this information.
- There were two long-term locums in post at the time of our visit.
- As of 1 February 2017, the planned total number of staff (whole time equivalent) for BMEC centre was 241, actual staff whole time equivalents, in post as of last recent month was 214 and the number of actual staff (whole number) was 250. Managers told us that shifts were always covered by sourcing staff from other departments or bank staff, who knew the service.
- ED consultants provided on call cover for 24-hours a day, seven days a week. ED doctors could contact them whenever they needed support or advice.
- Between 1 February 2016 and 31 January 2017, the medical turnover rate was 28% (not including junior doctors). The target was less than 11.7% over the year. There was no data available for BMEC ED
- The trust target for medical staff sickness rate was 2.4%. The rate for ophthalmology was 1.2% between 1 January 2016 and 31 December. There was no data available for BMEC ED
- The vacancy rate for medical staff as of 1 February 2017 was 13.2 %. There was no data available specifically for BMEC ED
- The turnover rate for medical staff in ophthalmology was 28% from 1 February 2016 to 31 January 2017. There was no data available specifically for BMEC ED.
- There were around 10 paediatric patients a year requiring emergency specialist paediatric ophthalmology procedures, within 24 hours. Managers at BMEC had identified themselves that there was a risk that children (particularly under three years of age) who attended ED would not receive either timely or appropriate treatment due to limited availability of out of hours specialist paediatric ophthalmologists and / or the availability of a paediatric anaesthetist. A senior manager told us that there had been no cases of harm coming to any children to date, due to contingency plans in place. This included for a general ophthalmologist to deal with out of hour's emergency cases, agreement with the local children's hospital to access paediatric specialist advice and patients could be transferred to the local children's hospital where specialist care was required. There was also a cohort of anaesthetists who were capable of anaesthetising children under three years of age who could provide back-up services when required. However, the consultants we spoke with acknowledged the contingency plan did not completely mitigate the risks and that counting on the goodwill of colleagues as opposed to a formal structure had so far ensured children's safety our of hours.

Major incident awareness and training

City Hospital Emergency Department

- We walked through the route and followed procedures for decontamination. The hospital has a good facility to isolate and decontaminate anyone arriving at the ED, if required. There was a separate, controlled entry point and a person can be fully isolated without risk of contact with others.
- Most staff could tell us about major incident policy and had some knowledge of major incident s. The shift coordinator would take charge of any potential major incident and staff would be used following the guidance in the policy.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- We saw a business continuity plan that was specific for BMEC ED. This covered telephonic and bleep failure, medical gas supply failure, loss of T systems, severe weather, major incident plan, lift failure, and loss of pharmacy. We saw solutions to deal with these events. For example in the event of telephonic failure, the solution included regular maintenance, use of mobile phones, use of email and an up to date list of medical staff mobile phone numbers kept in ED and updated every February and August when medical staff changed.

Are urgent and emergency services effective?

Urgent and emergency services

(for example, treatment is effective)

Good

We rated effective as good because:

- Multi-disciplinary team working had improved at City emergency department since our last inspection in 2014 and we saw medical and nursing staff worked well with each other and communication with other specialities was good.
- We saw staff gain verbal consent prior to treatment and saw evidence in-patient notes.
- Staff told us they had regular appraisals and we saw they were completed and recorded appropriately. During inspection, we saw that appraisal rates were 89%.

However:

- Between December 2015 and November 2016, the trust's unplanned re-attendance across both sites was worse than the England average.
- In some cases, we were not assured that actions from audits were clear and followed appropriately.

Evidence-based care and treatment

City Hospital Emergency Department

- All procedures and policies were based on the 'Clinical Standards for Emergency Departments' guidelines with staff being able to access them appropriately.
- We were shown the use of a sepsis-screening tool that identified patients at risk of sepsis and allowed staff to robustly manage treatment and care.
- Care pathways were in place for specific conditions in order to improve care. For example, staff showed us two examples of care pathways for the management of sepsis and asthma in children.
- The department was part of the trauma audit and research network (TARN). The audit network allows comparisons to be made with other trusts and consistency in treatment and care maintained.
- We saw plans to improve the current IT system by introducing new equipment. Staff told us that IT was the biggest challenge they faced and all welcomed the plan and the chance to improve patient care.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- BMEC ED participated in the national ophthalmology database. Results were unavailable at the time of our inspection.
- Staff followed policies and procedures in line with current best practice guidance including the National Institute for Health Care Excellence (NICE) and the Royal college of Ophthalmology guidelines. For example, we saw a protocol policy for Casualty Giant Cell arteritis (GCA).
- Staff used resuscitation algorithms for adult and paediatric patients. This provided staff with a simplified approach to resuscitationand life support.
- The lead consultant was a member of the committee for the British Emergency Eye Care Society, which had been set up to recognise emergency eye care in ophthalmology. This meant staff could contribute to developing practice in line with national benchmarks and guidance.
- BMEC ED did not participate in Royal College of Ophthalmology quality standards and self-assessments. However, this was a very recent scheme. BMEC did not participate in the Royal College of Emergency Medicine Audits. However many of these were not appropriate for the BMEC ED setting.

Pain relief

City Hospital Emergency Department

- Pain management was based on the Faculty of Pain Medicine's 'Core Standards for Pain Management (2015)', which had been incorporated into trust policy. Staff had access to the policy electronically.
- Pain scores were recorded when patients were first assessed during the streaming/triage process or at handover from ambulance staff. These were recorded in patient records and we saw that these had been reviewed and noted when patients had asked for more pain relief.
- We spoke to four patients at random about pain relief. All four told us that they had received pain relief and one said that they had asked for more pain relief and it was prescribed and administered without delay. All had their care plan explained to them and understood what was happening.
- Patients were asked to describe their pain using a numerical scale to enable staff to determine severity.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Staff told us not all patients were asked about their level of pain as a matter of course. Staff said they would only ask about a patient's level of pain if it was obvious the patient was in discomfort. However, the Royal College of Emergency Medicine, Best Practice Guideline, 2015 states 'Recognition and alleviation of pain should be a priority when treating the ill and injured. This process should start at triage, be monitored during their time in the ED and finish with ensuring adequate analgesia at, and if appropriate, beyond discharge'.
- Staff assessed pain in children using the Wong-Baker Faces pain rating scale. Thescaleshows a series of faces ranging from a happy face at 0, "No hurt" to a crying face at 10 "Hurts worst".
- Adults were asked to score their level of pain on a scale of 1 to 10, where 10 was the worst imaginable pain.
- We requested data on pain audits, however the centre did not provide us with the data.

Nutrition and hydration

City Hospital Emergency Department

- Patients were offered drinks regularly and told us that staff were considerate to their needs.
- We saw patients had fresh water available to them and that staff regularly checked them.
- There were vending machines available in the waiting area for patients and visitors to purchase snacks and drinks. They were stocked and in good working order at the time of inspection.
- In the CQC ED Survey, the trust scored 6.91 for the question "Were you able to get suitable food or drinks when you were in the Emergency Department?" This was similar to other comparable trusts.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Patients were unable to access water unless they purchased it from the restaurant. However, the restaurant was not always open. This posed a risk for patients such as the elderly and people with diabetes.
- The restaurant served hot and cold drinks and sandwiches on Monday to Fridays 8am to 3pm, until 5pm on Tuesdays.
- A shop sold hot and cold drinks and snacks Monday to Fridays 10.30am to 2.30pm except Wednesdays.
- In addition, there were vending machines selling various drinks and snacks on the ground floor; however, a member of staff told us that if this broke down on a Friday, it would not be fixed until the following week.

Patient outcomes

City Hospital Emergency Department

- The ED participated in national and local audits and followed guidelines set out by Royal College of Emergency Medicine (RCEM) and national institute for health care excellence (NICE). Results and action plans from audits were discussed routinely at operational and governance meetings. We saw six months of minutes from these meetings and there were audit presentations discussed at all of them.
- We were not assured in some cases that actions from audits were clear and followed appropriately. For example, an audit showed that blood sugars were not routinely taken for a child having a fit and there was no specific action identified for this.
- Between December 2015 and November 2016, the trust's unplanned re-attendance across both sites was worse than the England average. In the latest period, trust performance was 8.2% compared to an England average of 7.8%.
- Between January 2016 and December 2016, the Trust level monthly percentage of patients waiting between 4 and 12 hours from the decision to admit until being admitted for this trust was better than the England average.
- The royal college of emergency medicine (RCEM) set a number of national audits to monitor the performance of emergency departments. In the 2015/16 RCEM audit for vital signs in children, City hospital was in the lower quarter for four measures and upper quarter for one measure compared to other trusts.
- In the 2015/16 Procedural Sedation in Adults audit, City hospital was in the lower quartile for one measure. The remaining six measures were between the lower and upper quartiles. The measure that performed in the lower quartile was "Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area".

- Data from previous years include the audit for initial management of the fitting child, City hospital was in the upper quartile for one of the six measures and was in the lower quartile for one, showing an inconsistency of results.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- An audit carried out by a BMEC ED consultant showed that only 20% of referrals were genuinely urgent. As a result, BMEC ED was planning to reconfigure the service so that 80% of patients would be seen as urgent care and 20% as emergency. This meant an improvement to the service as patients would be given appointment slots within 72 hours.
- The lead paediatric consultant was undertaking an in depth review of paediatric patients attending BMEC ED. This was to help create a better understanding of who was accessing the service, to help develop guidelines and pathways to support decision making, to understand if there were other pathway options for children to access and to help target training requirements
- BMEC ED did not collect consultant sign off data to indicate whether a consultant reviewed each patient's care. The Royal College of Emergency Medicine recommend auditing this practice as published research indicates that consultant-delivered care reduces waiting times and length of stay, improves clinical outcomes and ensures that patients are only admitted to hospital if there is no reasonable alternative.
- Staff saw 17% of patients on the emergency nurse practitioner pathway, in line with the recommendation of the Royal College of Ophthalmology.

Competent staff

City Hospital Emergency Department

- Nurses told us that they were supported with the revalidation process. Revalidation was introduced by the Nursing and Midwifery Council (NMC) in April 2016 and is the process that all nurses and midwives must follow every three years to maintain their registration.
- Staff told us they had regular appraisals and we saw they were completed and recorded appropriately. During inspection, we saw that appraisal rates were 89% compliant against a target of 90%.
- The ED had clear induction processes for new members of staff. Staff we spoke with said they had felt supported when working in the department.
- We saw a new member of staff that was working alongside a nurse as part of their induction. The induction process was thorough with a combination of practical and educational guides to complete, along with a dedicated peer support.
- We examined the medical staff-training programme, which is available every week. The training was relevant to the ED and well attended by different grades of doctor.
- The PEM consultant was creating study sessions and a simulation programme to improve the skills of nurses and introducing training for doctors, three times a year.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Staff told us their appraisals were person centred meaningful and an opportunity to identify training opportunities. A hundred percent of staff had received an appraisal in the last 12 months, in line with the trusts policy.
- Staff told us of good training opportunities outside of mandatory training. For example, a specialist optometrist had completed a minor eye condition service, acute eye care course and an independent prescribing course.
- Emergency nurse practitioners worked to specific competencies and protocols that enabled them to manage a triage stream of patients with a wide range of ophthalmic conditions. These include conjunctivitis and corneal abrasion. We saw a wide range of competency frameworks for nurses that consultants signed off.
- Twelve out of nineteen BMEC ED staff held a post-registration ophthalmic qualification.
- There was a nurse led uveitis service. Consultants had assessed two nurses as competent and two more were undergoing training. Uveitis is inflammation of the middle coloured (pigmented)layer of the eye, called the uvea or uveal tract.

Multidisciplinary working

City Hospital Emergency Department

- Multi-disciplinary team working had improved since the last inspection, we saw medical and nursing staff worked well with each other, and communication with other specialities was good.
- A hospital liaison officer from West Midlands Ambulance Service was available at peak times in the ED. We observed good team working between ED staff and ambulance crews. Paramedics told us they had good working relationships with the ED staff of all levels.
- We saw good MDT working between staff in the ED and the GP's in the clinic. Patients were able to move between the two services with ease and we saw one patient that needed further tests, being transferred from the GP to the ED.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- BMEC ED staff had access to an alcohol and substance misuse team.
- Patients could self-refer into BMEC ED and were seen through appropriate pathways patients were only admitted to the eye ward if necessary.
- We saw good multi-disciplinary teamwork in the department. For example, we saw ophthalmic-trained nurses and emergency nurse practitioners working effectively with medical staff and health care assistants (HCAs) to deliver care.
- HCAs supported nurses to carry out assessments such as visual fields tests.
- An independent optometrist supported medical and other nursing staff. For example, the optometrist undertook the flashers and floaters clinics. Flashers and floaters are tiny spots, lines, flashes, or shapes in your vision.
- There were no formal service level agreements within the accident and emergency directorate relating to BMEC and their interactions with other units.
- The department worked closely with other general emergency acute departments to refer patients who became acutely unwell whilst at the trust. Staff transferred adult patients to the main ED department at the hospital and children to the local children's hospital if they became acutely unwell because of other general health problems.
- There were no formal service level agreements with other providers and the consultants told us that paediatric patients were kept safe informally and through the good will of colleagues across the region.

Seven-day services

City Hospital Emergency Department

- Staff told us that specialist services were accessible and that communication between departments was good. In most cases, an identified contact was available at any time for advice or support. Staff in the children's ED had contacts within children and adolescent mental health services (CAMHS) and dedicated paediatricians available 24 hours.
- Pharmacy support was available at core times between 8am and 10pm and an on call pharmacist was available out of these hours
- Consultants were available from 8am to 10pm seven days a week, with on call facility from 10pm onwards.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- The BMEC ED was open Monday to Friday 8.30am to 7pm (although the department was open until 9pm to allow doctors and nurses to see and treat patients who arrived after 7pm). The department was open at weekends. Outside of these times, patients could be seen at City Hospital's ED where facilities were provided to assess and treat patients with eye problems.
- The pharmacy was open Monday to Friday: 9.00 -13.00 and 14.00 -16.45. Patients could attend the pharmacy at city hospital between 13.00 and 14.00 if they could not wait for the BMEC pharmacy to re-open after the lunch break.

Access to information

City Hospital Emergency Department

- Staff had access to electronic information, policies, patient notes, assessments, and test results to ensure good care was given. We saw they were using early warning scores to aid in identifying issues and understanding the treatment required and sharing this information appropriately.
- We saw three capacity meetings, which were held daily in the morning afternoons and evenings, to assess the numbers of bed vacancies. These meetings were well managed and included the Sandwell site, to enable better cross-site management. The systems used a red/green coding to categorise the potential vacancies or issues and give a visual indication of the bed state across the trust.

- All staff, including bank and agency, had access to information on the internet. They could access incident reporting, policies and via email. The matron could authorise one day IT access to the system if required.
- We saw information displayed in the staff room and multi-disciplinary training room. Sickness levels, appraisal rates, mandatory training compliance and some audit results were clearly displayed for staff.
- Information technology (IT) systems were not ideal and staff told us that there were problems in accessing some data and in particular, printing information was difficult. The trust had recognised the issues and a plan to upgrade the IT systems is underway.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Policies and standard operating procedures were available on the intranet for staff to access. Staff also had access to the on-line British National Formulary to provide up to date information about the use of medicines. Staff showed us that these were easily accessible.
- Patient discharge letters were sent to GP's upon discharge and a copy was retained in patients' notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

City Hospital Emergency Department

- We saw staff gain verbal consent prior to treatment and saw evidence in-patient notes. We also saw 10 examples of written consent being recorded in randomly chosen patient notes.
- Staff told us that they always presumed a patient had capacity to consent to treatment, but if there were signs of patients not understanding or finding it difficult to communicate, they would assess the capacity of the patient.
- A lead nurse for dementia was available and wherever possible would assess patients with dementia. Dementia screening tool was used to aid in the assessment and we saw examples of these being used.
- Staff in the ED, had a good understanding of the need to gain consent and used the Gillick assessment if appropriate. The 'Gillick Competency Assessment' helps clinicians to identify children aged 16 or under who have the legal capacity to consent to medical examination and treatment.
- DoLS information was clearly displayed on a wall in the minor's area. Staff could use this as a prompt and patients or visitors saw this as good information.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Staff we spoke with told us patients who lacked capacity always presented with a relative or carer**.** A senior member of staff told us patients implied capacity by way of the fact the patient had presented to the department for medical assistance**.** This indicated staff might not have fully understood the Act and what it meant for the care and treatment of people.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- We saw patients being cared for with compassion and staff were considerate to patient needs.
- One patient told us they arrived late in the evening and was cared for well despite the ED being busy.
- Patients and family told us that they were kept informed of the treatment plan and that staff were approachable.
- There was access to a multi-faith chaplaincy team to support patient and families in the event of a death or for other pastoral needs.

However:

- Friends and Family Test performance across both sites was worse than the England average. In December 2016, trust performance was 79% compared to an England average of 86%.

Compassionate care

City Hospital Emergency Department

- We saw patients being cared for with compassion and staff were considerate to patient needs. One patient was restless we saw staff reassure them that they were safe and being looked after in the hospital.
- We observed staff dealing with a difficult situation where a patient was complaining about waiting for test results from a GP. Staff explained that it was not appropriate to attend the ED for the results, but

arranged for them to be checked over by someone before leaving. Staff dealt with this sensitively and fairly even though the patient was behaving in an aggressive way.
- One patient told us they arrived late in the evening and was cared for well despite the ED being busy. They described the care as "excellent and said that the staff did an incredible job.
- Other patients told us that that the staff were kind and helpful. One said that he was confused and nervous but a nurse had explained what was happening and this had put them at ease.
- Between January 2016 and December 2016, the trust's Friends and Family Test performance across both sites was worse than the England average. In December 2016, trust performance was 79% compared to an England average of 86%.
- Friends and family results for City hospital ED showed that 77% would recommend the hospital and that the care received was good. This is above the national average for similar hospitals.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- All of the staff we spoke with were positive about the level of care they received and told us that staff were kind and compassionate.
- Patients could overhear consultations with other patients due to the open plan layout. Staff were therefore unable to protect patients' dignity and privacy. However, there was a room available for private consultations.
- The PLACE score for privacy and dignity was 89% compared to the national average of 83%.
- We saw staff from the main hospital had brought a female patient to BMEC ED and left her in the corridor of the BMEC ED waiting area. She was clearly disorientated and left alone in her hospital gown unattended. This compromised her safety and dignity as she was at high risk of falling and the open backed hospital gown could have compromised her dignity.
- The response rate for the friends and family test in October 2016 was 7% and the percentage of patients who would recommend the service was 77%. In November 2016, the response rate was 6% and 85% of patients would recommend the service. This was the most recent data we were provided with.

Understanding and involvement of patients and those close to them

City Hospital Emergency Department

- Patients and family told us that they were kept informed of the treatment plan and that staff were approachable. Patients that were under the age of 18 were included fully in the discussion about care.
- One 13 year child told told us that they had been asked questions and discussed the treatment options, even though their parents were there with them and this made them feel included.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- The main complaints patients made to us were relating to the lack of communication about waiting times. There was no information system in the reception area providing details of the average waiting time. There were screens that could have been used for this purpose and for other purposes such as promoting health improvement messages for patients as they waited for their appointments.

Emotional support

City Hospital Emergency Department

- There was access to a multi-faith chaplaincy team to support patient and families in the event of a death or for other pastoral needs. Staff knew how to contact the bereavement team and counselling services, if required.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Patients could access emotional support in the multi-faith chaplaincy service within the main hospital.
- Counselling services were available via the ECLO for patients such as those being diagnosed with lifelong conditions or those losing their sight.

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

Requires improvement

We rated responsive as requires improvement because:

- Information for the trust from February 2017 shows that 82% of patients spent less than 4 hours in the ED, which is below the national average of 85.5%. Results for January 2016 show 91% indicating a decrease over the 12-month period. For children's ED this percentage remained consistent at 100% for the same period.
- For the period, January 2016 and December 2016 the England average rate of patients leaving without being seen was 2.8%. During the same period, the average for the department was 3.8%.

However:

- The children's ED was adjacent to the main ED and separated visually and audibly to ensure better privacy and safety.
- We randomly observed four patients being triaged; the assessments were safe and appropriate.
- Translation services were available on request for patient's whose first language was not English.

Service planning and delivery to meet the needs of local people

City Hospital Emergency Department

- The children's ED was adjacent to the main ED and separated visually and audibly to ensure better privacy and safety. It was open seven days a week from 10 am to 10 pm and consisted of four cubicles, one isolation bay and a monitored bay with the paediatric resus area being located in the main ED.
- Staffing in the children's ED consisted of four nurses working 12-hour shifts. They were all trained in paediatric immediate life support (PILS) and at least one is a specialised paediatric nurse. However, we were told that on occasions a paediatric nurse was not on duty. We checked staff rotas and noted that this had happened once in the previous week and was a regular occurrence each week. Support was available from specialist nurses from within the hospital.
- The children's ED had a designated play area for children and there were a variety of toys and games available. There was not a specialist play worker or healthcare assistant available to supervise the play.
- A GP clinic was situated in the ED which patients could be directed to if appropriate. A nurse would assess patients' needs and direct them to either the ED or GP areas. Patients' could access the ED once seen by the GP if required.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Paediatric patients were seen in a mostly adult environment with no safeguarding processes in place to keep children safe. However, staff told us children were seen as a matter of priority. This helped reduced the time the children were in the department.
- The consultants we spoke with were strongly in favour of the provision of an integrated paediatric emergency eye service across the region. However, they told us that their external colleagues did not support this, as they did not wish to be part of a regional out of hour's rota.
- There was not enough seating and space in the reception and waiting areas for people to sit whilst they were waiting to speak to reception staff or for their consultation.
- BMEC ED was to undergo a major service re design, with a shift to the provision of a wider range and larger number of urgent care clinics. The rationale behind this was that that currently the majority of attendances to the department were emergency patients. Most cases could be triaged to receive semi-planned care. The redesign aimed to help free up the eye casualty for true emergencies.
- Staff we spoke with was unaware of the trust's plans for their department in relation to the opening of the new Midland Metropolitan Hospital. Management were therefore unable to tell us how their service was being planned and adapted to meet the needs of the local population in the future. For example, they were uncertain as to the future plans regarding the provision of the ED.

Meeting people's individual needs

City Hospital Emergency Department

- We saw cubicles that could be used for patients with dementia. There was a butterfly sign displayed as a visual aid to indicate that a patient might have different requirements or be more vulnerable.
- We saw a bay being used to monitor patients requiring increased support. The staff ratio was 2 to 1 and visibility and access for all staff was good. Support was available in case of emergency.
- We randomly observed four patients being triaged; the assessments were safe and appropriate. One patient identified as having sepsis was put on the sepsis

pathway, the nurse in charge was informed, and correct protocol followed. Another was assessed for pain levels and analgesia given. All received good care and were communicated with throughout the treatment.
- Translation services were available on request for patient's whose first language was not English. Staff told us they also had support from staff that were fluent in a variety of languages.
- There were vending machine facilities, access to toilets, and TV's were mounted throughout the area. However, on every occasion we visited, the TV's were not switched on. Staff told us that they were not working correctly and remained switched off until they were repaired.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- A nurse told us that they checked a box on the patient assessment form to identify whether patient's condition was alcohol related or not. The nurse said that if the condition was alcohol related no further action would be taken as the question was for audit purposes only. This missed an opportunity for BMEC nurses to identify people who were drinking at harmful levels.
- New information leaflets and pre-printed consent forms for common procedures were printed black on yellow. This was in line with the Royal National Institute for Blind People guidance.
- Staff reported that they could access interpreting services through a help line when required. They told us this service worked very well.
- Face to face and British sign language services were booked in advance and could be made available for patients attending a follow up appointment.
- A computer-based translator was accessible on the BMEC website to enable information to be translated into a range of languages. However NHS Choices states the translated text is not of the same quality as if it had been translated by a human translator. This also means that there is a difference in quality of translation between the languages.
- Information on domestic violence services, including rapid self-referral organisations were readily available and displayed on patients information boards.
- The electronic patient records system did not enable staff to highlight patients with special needs such as dementia or learning disabilities, cancer or other specialist needs such as language barriers.
- The PLACE score for dementia was 86% compared to a national average of 73% and the PLACE score for disability was 89% compared to a national average of 77%.
- Staff prioritised children and patients with complex needs during the triage process. This ensured they were not kept waiting too long.
- The trust employed a dementia lead nurse. Staff did not routinely refer patients to the lead; however, staff could contact the lead by telephone or email for complex cases. A central dashboard was kept to record all referrals to this professional.
- The trust contracted in a specialist learning disability service. Two registered learning disability nurses covered the trust.
- Identifying and recording factors that may contribute to a patient's vulnerability can be a vital first step in ensuring that he or she receives necessary support. Staff were unable to verbalise what they would do if patient presented unaccompanied with suspected cognitive impairments, such as dementia. Staff told us a relative or carer always accompanied patients with cognitive impairments such as learning disabilities and dementia and they never presented on their own.
- Staff told us there was no system in place for monitoring vulnerable patients in the waiting room, such as elderly patients who are at greater risk of dehydration.
- Birmingham Midland Eye Centre employed an eye clinic liaison officer (ECLO) that was based at the hospital. The ECLO offered specialist support services for patients who were losing their sight. The ECLO also provided support in cortical visual impairment explanations, general discussion of their needs, employment advice, mobility, managing day-to-day tasks, financial benefits, social activities, and contact with others with impaired sight and using technologies. The ECLO told us he could signpost patients to counselling services.

Access and flow

City Hospital Emergency Department

- Median time for arrival to treatment should be no more than one hour. The standard was met for eight months between December 2015 and November 2016 and fluctuated near to the standard for the rest of the time. The median time for November 2016 was 63 minutes against the national average of 59 minutes. However, March 2016 saw a peak of just over 70 minutes.

Urgent and emergency services

- Over the 12 months between January 2016 and December 2016, most patients never waited more than 12 hours from the decision to admit until being admitted.
- In the period between January 2016 and December 2016, there were 12647 ambulance journeys with a turnaround above the target of 30 minutes, of which 135 were delayed for more than 60 minutes. On average 45% of all ambulance turnaround times were over 30 minutes for the same period.
- For the period, January 2016 and December 2016 the England average rate of patients leaving without being seen was 2.8%. During the same period, the average for the department was 3.8%.
- Information for the trust from February 2017 shows that 82% of patients spent less than 4 hours in the ED, which is below the national average of 85.5%. Results for January 2016 show 91% indicating a decrease over the 12-month period. For children's ED this percentage remained consistent at 100% for the same period.
- The percentage of ED attendances at this trust that resulted in an admission was lower than the England average in 2016 at 17.8%.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- The BMEC ED saw approximately 2000 adult and children patients a month.
- There were 29311 attendances between 31 January 2016 and 22 January 2017.
- Between April 2015 and March 2016, 12% of patients attending ED were 0-16 years of age and 88% were 17 years plus.
- There were clear patient pathways that eased the flow of patients within the department. The department had implemented an active triage system where staff treated patients in order of priority.
- Ophthalmic-trained nurses provide advice between 9am and 4pm over a dedicated telephone advice line to patients, professionals and other services. After 4pm the pre triage nurse operated this line.
- Unplanned re attendance rates between April 2016 and March 2017 ranged from 2% to 4% (within 7 days).This was better than the national standard of 5%.
- Between April 2016 and March 2017 BMEC ED achieved 98 to 100 % compliance with the national A & E waiting time target.
- We asked BMEC ED for data regarding the number of patients leaving without being seen in the last twelve months; however, they did not provide us with this information.
- Patients very rarely arrived to BMEC ED by ambulance and staff told us if they did medical staff would attended to them immediately. We requested ambulance waiting times, however BMEC ED did not provide us with this data.
- No BMEC ED patients waited over 4 hours from decision to admit toadmission between April 2016 and March 2017.

Learning from complaints and concerns

City Hospital Emergency Department

- Staff coordinated and reviewed complaints and investigations done, where appropriate. Learning from investigations was discussed at monthly governance meetings and staff meetings.
- Staff knew how to raise a complaint or inform patients on the process. The nurse in charge would try to deal with any issues at the time. Information about patient advice and liaison services (PALS) was available in reception with posters displayed throughout the hospital. We did not see any specific examples of patients being directed to the PALS department. Initially PALS dealt with complaints, but the matron or a senior member of staff would investigate to provide information for a reply.
- Staff told us that compliments and "thank you" cards were read out at team meetings or handovers and displayed in the ED.
- We randomly checked November 2016 for complaints and found there were five for City hospital ED. Two were dissatisfied with treatment, two were failure or delay in diagnosis, and one was lost property.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- The department manager told us that the main themes of complaints related to waiting times, short consultation times and staff attitudes.
- Between 25 February 2016 and 17 November 2016, BMEC ED received 15 complaints. Management upheld

five of these. Two concerned long waiting times, one, the font size on an appointment letter, one concerned staff attitude and one was about a patient not being followed up as planned.

- All the patient waiting areas had leaflets advertising the services of Patient Advice and Liaison Service (PALS) and provided information about how to complain. Patients we spoke with were aware they could raise any issues with staff in the department or seek assistance from PALS if needed
- Staff were aware of the action to take if someone raised a complaint or concern with them and said they would escalate it to senior staff. They said patients would be encouraged to involve PALS where appropriate
- The department manager took a proactive role in resolving complaints directly with people. For example, if a member of staff received a complaint from a patient or visitor, they immediately escalated this to the service manager who would meet the person for a discussion.
- We reviewed BMED ED's response to two complaints. One of the complaints related to a patient being unable to get through to the right person in the department via the telephone service. The governance director wrote to the patient to explain that they had reviewed the telephone system and had added extra options for patients to choose when dialling the generic BMEC ED number. Instead of patients being given three department numbers to choose from they were now given additional options including the contact lens and optometrist departments so that they could contact the correct department in a timelier manner.
- Staff told us that management shared learning from complaints at the monthly quality improvement half days.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Some safety and cultural issues were not addressed for example, staff told us that the rotation of staff between sites was not liked and that they were not comfortable when working at Sandwell General Hospital.
- There was a lack of consistent management across the two main sites. We spoke to staff from Sandwell hospital that were at City hospital on rotation and were told that the environment was better at City hospital.
- Staff in the ED told us that the proposed move to the new site in 2018 had been causing some concerns and that the emotional support for staff, was lacking.
- We saw little evidence of good public engagement at the main ED or within BMEC.

However:

- Local leadership was good across City Hospital and BMEC and we saw the manager available to staff for support.
- The PEM consultant was creating learning opportunities for staff, introducing a consistent approach to work within children's' ED.
- We saw examples of incidents being reviewed and information about actions being shared with staff across both Ed services.
- Staff morale was high and there was an improvement on team working from our last inspection.
- Staff told us that the initiative "it's OK to challenge" had allowed them to feel comfortable in asking anyone questions or making requests.
- We saw information displayed in the RAT area that showed performance indicators and any breeches in that area.
- Staff demonstrated a social media page that enabled them to communicate when cover was needed in the department.

Leadership of service

City Hospital Emergency Department

- Local leadership was good and we saw the manager available to staff for support.
- Bank staff told us that the matron supported them and that the same opportunities were open to them as the regular staff.
- The matron was visible in the department and works as part of the team. We saw that they helped nurses during busy periods and was available to speak to patients.
- Some staff told us that the executive team were not as visible in the ED department during busy times and they could attend to show support or thank the staff on occasions.

- The PEM consultant was creating learning opportunities for staff and introducing a consistent approach to work, within both children's' ED.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- The ophthalmology service was part of the surgical services directorate. A clinical director, lead nurse (matron), and general manager led the directorate. The directorate reported to the surgical services group director, group director of nursing and group director of operations.
- Senior managers in BMEC ED told us the centre was recognised nationally, for its specialised work as a tertiary referral centre, but they felt their own trust did not realise what they did, and said there was a knowledge gap among senior executives. They gave us examples of poor communication from trust executives about changes to their services and structure, and told us they did not feel the trust executives valued the work done in BMEC. They told us the centre provided 20% of the trust's activity with less than 7% of its funding.
- The clinical director was an ophthalmologist and the lead nurse was a children's trained nurse. Staff we spoke with felt supported by their local leadership team. However, staff also told us they would like to see greater recognition and support of the paediatric service.
- We saw good local leadership within the department and staff reflected this in their conversations with us. However, staff told us the executive team was not as visible in the department.
- Staff were supported in their roles and had opportunities for training and development.
- The management had oversight of the risks with the service and mitigating plans were in place.
- Patients were engaged through surveys and feedback forms.
- The clinical leadership team had implemented quality improvement projects to deal with the increasing demand on the service.
- Staff told us and management confirmed team meetings did not take place. This was a lost opportunity for staff to share and exchange information, receive feedback and offer support to one another.

Vision and strategy for this service

City Hospital Emergency Department

- There was a clear plan to facilitate the opening of the new hospital in October 2018. Staff in the ED told us that the move had been causing some concerns and that the emotional support was lacking. They were not sure how to control the anxiety that the changes were causing.
- Staff in the ED could tell us the vision for the trust and talked about the countdown to the opening of the new site. We were not assured that all staff were confident in achieving this target and they told us that there was a lot to do in the time left.
- We were assured that the staff were confident in the current working practice at City hospital ED. There was a good team spirit and pride for the work done in the ED department and staff told us patient care was a priority.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- The leadership team had a clear focus on improving access and flow in the department, ensuring the department met the demands associated with year on year increase in patient attendances.
- The trust wide vision for 2016-2019 focused on: safety plan, patient experience, electronic patient records, and the development of a new hospital site. Staff we spoke with could not describe the trust vision or strategy, however they were able to tell us about the trust's care promises

Governance, risk management and quality measurement

City Hospital Emergency Department

- A monthly electronic performance report was produced, which was reviewed by local managers. It provided information on incidents, complaints and performance indicators for the ED and was used, along with governance meeting minutes, to inform ED staff at team meetings. Copies were available for staff located in the staff room.
- Risk was reviewed monthly at the emergency medicine operational and governance meeting. We saw information for the period June 2016 to January 2017, which showed risks had been discussed and action or mitigation put in place. In some cases, the risk had been escalated. For example, the paediatric liaison services were due to cease on the 31 March 2017. This had been raised as a risk and options discussed to mitigate risk.

- Matrons from both sites would share information at governance meetings and met independently to discuss issues concerning the two ED's.
- We saw examples of incidents being reviewed and information about actions being shared with staff in the ED. Information was posted in staff areas and verbally shared at handovers or team meetings.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- Managers held quarterly governance meetings, which linked to the surgical directorate governance meetings. We saw minutes of the meetings held in April, July and October 2016, and January 2017. We saw there had been discussions in areas such as clinical effectiveness, risk management, complaints, incidents, risks, and patient feedback. The minutes also detailed how the department was performing in areas such as staff appraisals, and mandatory training.
- We reviewed the risk register. This showed the management team had oversight of the risks within the services and mitigating plans were in place.

Culture within the service

City Hospital Emergency Department

- We saw good teamwork in the ED reception area. Staff told us that a manager supported them and that staff were available to support decisions or answer questions arising from the initial contact with patients.
- Staff were supported in their development and we saw a newly promoted sister that told us how well she had been coached through the progression.
- Staff told us that they were developed from being an apprentice to a full time member of the ED staff. They completed NVQ's and supported in the learning the role in ED reception.
- Staff morale was high and there was an improvement on team working from our last inspection. Staff described the ED at City hospital as "a big happy family" and "a great place to work".
- Staff told us that the rotation of staff between sites was not liked and that they were not comfortable when working at Sandwell hospital.
- There was a lack of consistent management across the two main sites. We spoke to staff from Sandwell hospital that were at City hospital on rotation and were told that the environment was better at City hospital.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- All of the staff we spoke with told us about a positive local working culture in which they felt valued and respected. Staff felt they could approach all levels of staff including the matron and consultants.

Public engagement

City Hospital Emergency Department

- We saw displayed over 30 "thank you" cards or letters from patients complimenting staff and praising the ED.
- There were suggestion boxes situated throughout the hospital to enable patients, staff and visitors to leave feedback. Social media and the trust website were available for patients to access and leave feedback or get information about the hospital.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- A keratoconus group meeting took place every three months. Keratoconusis a non-inflammatory eye condition.
- A PINGU (Patient Involvement Group in Uveitis) meeting took place on a quarterly basis. This is a group of patients, nurses and doctors who meet together to try to improve understanding of uveitis and its treatment.

Staff engagement

City Hospital Emergency Department

- Staff told us that the initiative "it's OK to challenge" had allowed them to feel comfortable in asking anyone questions or making requests. For example, they told us, hand hygiene had improved in the ED because staff felt comfortable in challenging non-compliance and were supported by the manager.
- We saw information displayed in the RAT area that showed performance indicators and any breeches in that area. For example, there was a breakdown of the cost of breeches for the previous week.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

Urgent and emergency services

- Senior managers told us the trust's senior management team regularly proposed changes to the centre without consultation. They gave us an example of the trust's decision to close the eye ward, and told us this was despite it being the only regional service of its kind.
- The trust provided quality improvement half days for staff. These were protected learning times for teams where non-essential clinical services were stopped one afternoon every month. Content include areas such as lessons learned from incidents and near misses, how to make basic safety standards consistent across all areas, improving patient experience, training and development and latest research updates.
- Staff felt uncertainty with regard to the future of the service and did not feel involved in the decision making process. We heard that senior and executive management had announced recent decisions about changes to the service without prior notice to staff.

Innovation, improvement and sustainability

City Hospital Emergency Department

- Staff demonstrated a social media page that enabled them to communicate when cover was needed in the department. Managers could post requests for cover or staff could communicate their availability to cover. Staff favoured the system, as it seemed to be an efficient way to assist in managing staff issues.

Birmingham and Midland Eye Centre (BMEC) Emergency Department

- We asked BMEC ED for examples of innovation, improvement, or sustainability. BMEC ED did not provide us with this information.

Medical care (including older people's care)

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

Information about the service

The City Hospital is one of two acute hospitals within the Sandwell and West Birmingham NHS Trust. Medical services are provided at both acute hospital sites.

Medical services at City Hospital in Birmingham include acute medicine, general medicine and older people's care and some specialties including cardiology, respiratory, renal, haematology and oncology. There are also two endoscopy suites. Other specialties such as stroke services are provided at other sites within the trust and are therefore not included in this report.

There were 32,315 patient spells in medical services at the City hospital between 1 October 2015 and 30 September 2016.

We carried out an unannounced inspection on 16 February 2017 and an announced inspection between 28 March 2017 and 30 March 2017.

During the unannounced inspection we visited all of the medical wards and the two acute medical units (AMUs) and during our announced inspection, we visited AMU2, ward D5, ward D7, ward D15, ward D16, ward D26, the oncology day unit and an endoscopy unit.

We spoke with 49 staff in addition to meeting with members of the senior leadership team. We also spoke with 14 patients and relatives. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed 17 care records and observed board rounds, ward rounds and the clinical handover of patients between shifts. We reviewed other documentation from stakeholders and performance information from the trust.

Medical care (including older people's care)

Summary of findings

We rated this service as Requires Improvement because:

- Medical services were one of the areas of most concern at the trust and had been so for the past two years. Although there had been significant improvements across this service since the last inspection, progress was slow.
- We found a range of concerns in relation to the safety of care including the prescribing of medicines and low staff attendance at some mandatory training such as basic life support training.
- There was limited learning from incidents and safety concerns were not always addressed promptly. We found this in relation to infection prevention and control, the contents of emergency resuscitation trolleys and the management of patients living with dementia.
- There was inconsistency in the application of the Mental Capacity Act (2005) when people were unable to make some decisions for themselves. Decisions about people's care had been made without evidence of mental capacity assessments being completed or evidence of how decisions were made in their best interests. Deprivation of Liberty Safeguard (DoLS) applications which are required to provide authorisation for a person's freedom to be restricted to maintain their safety, did not always contain the information required to ensure the safeguards were being applied appropriately and in the person's best interests.
- There were variations in the quality of management and leadership, leading to a lack of consistency in care processes and which impacted on the effectiveness and responsiveness of care.
- Delays occurred at most stages of the patient journey from admission to discharge.

However:

- The service took account of the needs of vulnerable patient groups including those with a learning disability and those who were unable to speak English. Adaptations had been made to the environment to better meet the needs of patients living with dementia and an activities coordinator provided therapeutic activities for those living with dementia or with delirium and those without outside contacts.
- The outcomes for patients undergoing care for specific medical conditions were measured and compared with other trusts through participation in national clinical audits. The outcomes for patients with heart failure and following heart attacks were in line with or better than the national average.
- There were some improvements in key performance indicators relating to the quality and safety of care. Managers were aware of the issues in relation to the consistency of care and an improvement programme to reduce delays in the patient journey from admission to discharge was underway.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

We rated safe as Inadequate because:

- There was limited evidence of learning from incidents, and morbidity/mortality reviews.
- Safety concerns were not always addressed promptly and opportunities for learning were missed.
- The prescribing of medicines was not completed in line with nationally recognised standards.
- Staff attendance at some parts of mandatory training was low. For example, only 68% of staff were up to date with resuscitation training.
- The high use of temporary nurses required to achieve the required staffing levels and the absence of a systematic approach to checking their competencies, gave us concerns about the safety of care particularly on ward D16.
- Issues we identified with medical staff attendance were not escalated within the trust and staff were not aware of a clear route for escalation.
- There was incomplete implementation of national guidance on sepsis and acute kidney injury, both of which ensure early diagnosis and treatment to improve outcomes for patients with these conditions.
- Although the trust used the national early warning score to identify when patient's condition deteriorated and we saw examples of appropriate responses, when the score rose, the trust did not monitor the escalation pathway and whether patients were reviewed within the agreed timeframe when their NEWS increased.

However:

- Staff were aware of the process for reporting adult safeguarding concerns. 99% of staff had completed level 1 adult safeguarding training and 91% were compliant with level 2 training.
- We observed good adherence to hand hygiene procedures
- Performance in the national safety thermometer had improved.

Incidents

- Between February 2016 and January 2017, the trust reported no Never Events for medical services. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the trust reported 16 incidents in medical services at the hospital between January 2016 and December 2016, including eight falls, five pressure ulcers, two infection control incidents and an unauthorised absence.
- We reviewed the investigation report for the incident of unauthorised absence and found there was an analysis of the incident and contributory factors. An action plan was developed to reduce the risk of a similar incident occurring in the future. The patient involved in this incident was living with dementia and their confusion contributed to their leaving the ward. However, when we visited wards during the inspection, we found there continued to be gaps in staff knowledge of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2007) which protect people when they cannot make some decisions for themselves and patients' records did not fully document the impact of their dementia on their behaviour. There was no evidence of the use of a dementia/delirium pathway. As a result, we could not be confident lessons from the incident had been fully learnt.
- Most staff we spoke with told us they were encouraged to report incidents, however, some medical staff told us incident reporting was not encouraged.
- Staff knew how to report incidents on the electronic reporting system and we were told staff at Band 6 and above, were provided with feedback via email, following the investigation of the incident. Junior staff were given feedback by their line manager. Some said they were given feedback at handover and others said they received emails from their manager.
- However, some staff told us of incidents which were reported and for which they had not received feedback over two months after submission of the incident. They were concerned as to whether any action had been taken to prevent recurrence as there had been no communication and no changes had been evident as a result. One example was for two incidents related to the accuracy of CT scan reports. The person said they had received two reports, which did not correspond with the clinical diagnosis of the patient and the report did not

reflect the scan results. We asked the trust for information about these incidents but they did not provide it. We therefore had concerns about the review and investigation of incidents. When we asked staff about learning and changes put into place as a result of incidents, all nurses we talked with at the announced visit told us about checks of medicines charts put into place at the end of each shift to reduce the number of omitted signatures on the charts. They were not able to recall any other changes. However, we were given some examples of other changes when we asked similar questions at the unannounced visit.

- Staff said they discussed incidents and lesson learned from incidents at the monthly governance meetings and we saw evidence of this in the minutes of the meetings.
- Staff said they were open and honest when things went wrong. They said they provided a full explanation and apology to patients.
- The approach to reviews of morbidity and mortality varied across the specialties in medical services. Some specialties had morbidity and mortality meetings whilst others told us they incorporated it within the monthly clinical governance meetings or the quality improvement half days. However, we did not always see evidence of this in the notes of the clinical governance meetings and most specialties did not produce a record of discussions and learning from the reviews.
- We were told all deaths were reviewed with 42 days by a clinician within the specialty however, records of the reviews were not available.

Safety thermometer

- The NHS safety thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections.
- Data from the Patient Safety Thermometer showed that the trust reported 22 new pressure ulcers, 16 falls with harm and 15 new catheter urinary tract infections between January 2016 and January 2017. Rates from all three fluctuated throughout the year.
- Medical wards at the hospital reported no new harms in January 2017 whilst in December 2016 ward D11 and ward D7 showed the greatest percentage of harms with new harms of 9% and 11% respectively.
- Senior ward sisters were generally aware of their ward's performance in relation to the safety thermometer and safety crosses were displayed on the ward and used to track pressure ulcers and falls each month.
- Staff knowledge of initiatives to reduce pressure ulcers and falls was variable. For example, we spoke with a sister and a senior ward sister and neither were able to identify any actions taken to reduce falls apart from increasing nurse staffing levels. However, a band 5 staff nurse on another ward told us they ensured the falls care plan interventions were completed, patients were placed where they were easily visible to staff and that physiotherapists and occupational therapists could be utilised to assess patients' mobility prior to them starting to mobilise.

Cleanliness, infection control and hygiene

- Methicillin resistant staphylococcus aureus (MRSA) is a type of bacteria that is resistant to a number of widely used antibiotics. One MRSA bacteraemia (blood stream infection) was reported in medical services at the hospital between April 2016 and December 2016. We reviewed the action plan arising from the investigation of the incident and found it had been investigated appropriately.
- MRSA screening is recommended for specific groups of patients at high risk of MRSA. This helps detect patients who may be carrying the organism in order to minimise the risk of the patient becoming infected and to minimise the risk of transmission to other vulnerable patients.
- In December 2016, 44% of elective admissions and 91.3% of emergency admissions eligible for screening were screened within the recommended time frame, against a trust target of 95%. As a result of the low levels of screening of elective patients, it is possible that patients with MRSA would not be detected.
- The trust reported nine C. difficile infections in medical services at the hospital between April 2016 and December 2016.
- A C. difficile infection occurred on ward D16 and within a short timeframe, two other patients colonised with the same strain of C. difficile were identified. As a result, the trust completed an investigation to identify whether there was any cross infection and whether the appropriate decisions were made in relation to the person's antibiotic treatment. The results from the investigation were inconclusive. There was no

consultant representation at the review meeting despite the meeting having been organised to enable their attendance. As a result, at the meeting it was not possible to understand the rationale for some of the decisions.

- We asked about consultant representation at other investigatory review meetings for C. difficile and were told there was no automatic request for medical representation, as they were rarely identified a lapse in care. However, we would have expected the rationale for prescription of antibiotics and the use of specific antibiotics to be explored at all investigatory review meetings for C. difficile and medical staff would be the prescribers.
- During both inspection visits we observed good hand hygiene practice.
- Hand gel was available at the entrance to each ward and at every patient's bedside. Sufficient hand wash basins were also available within the wards for handwashing.
- Staff completed hand hygiene audits on a monthly basis to check compliance with hand hygiene procedures. The trust had set a target of 95% compliance and for the year January 2016 to December 2016; all the medical wards met the target for at least 11 of the 12 months except ward D7 which scored 74% in March 2016 and 61% in July 2016.
- During the unannounced inspection, we heard staff reminding others about the need for hand hygiene and we were unsure as to whether this was happening because hand hygiene was not embedded in practice, although it showed a willingness of staff to challenge others.
- During the unannounced visit, three patients told us staff did not always clean their hands before attending them, however, during the announced inspection, all the patients we asked about this answered positively.
- The trust participated in the Patient Led Assessment of the Clinical Environment (PLACE) audit during 2016. All medical wards involved in the audit scored 97% or above for cleanliness in the audit. This met the national target.
- Daily and weekly cleaning schedules were displayed on each ward and clinical area. Housekeeping staff were knowledgeable about the daily cleaning requirements and the procedures when a patient had an infection.
- Side rooms were available on the acute assessment unit (AMUs) and there were two rooms with negative pressure ventilation on AMU1. However, other wards had few side rooms and there was no isolation unit/ ward at the hospital. As a result, patients with infections remained on AMU for an extended period and some patients who developed an infection during their stay were moved back to AMU.
- At the time of the unannounced inspection, there were insufficient side rooms to accommodate patients with an identified or suspected infection and two patients with confirmed influenza were cared for in a ward area with other patients. Although other patients on the ward were given medication to prevent them developing influenza, best practice would be to care for the patients with influenza separately from others.
- During our unannounced inspection, we observed a member of staff using personal protective equipment and clothing (PPE) when entering a room being used for a patient with an infection, however we noted they took the vital signs observation equipment into the room and brought it out again. This increased the risk of the spread of infection.
- A recommendation in the action plan developed as a result of a C. difficile investigation in July 2016 was to ensure that disposable blood pressure cuffs were used for patients being isolated. The observation we made on 16 February 2017 at our unannounced inspection, suggested the action plan was not fully implemented.
- The endoscopy unit was visibly clean when we visited and equipment was stored appropriately. The trust was following Department of Health guidance on the decontamination of flexible endoscopes. Arrangements were in place for the separation of dirty and clean endoscopes and their decontamination. Appropriate measures were in place to track and record the removal of scopes from storage and track their use.

Environment and equipment

- Staff gained access to wards and clinical areas with electronic swipe cards. Visitors gained access using a call bell, which enabled staff to monitor visitors and patients entering and leaving the wards.
- The medical wards were allocated as male or female wards as the layout did not allow single sex accommodation requirements to be met if male and female patients were accommodated on one ward.

- Storage areas were keypad entry and kept locked when not used. Some wards, in particular the two cardiology wards, were cluttered with unused equipment and procedure trolleys.
- We observed there was a blocked hand wash basin on one ward and a blocked toilet on another ward. We were told the toilet had been out of use for a week. A member of staff said, "A toilet or sink is blocked nearly every day." "Maintenance says the pipes are old and it is how they are bent." Although staff said they contacted the maintenance department, there were delays in rectifying the problems.
- The oncology unit provided a bright airy environment for patients, with comfortable chairs in the waiting room and consulting rooms with adequate space.
- The trust maintained the environment in the endoscopy unit to a reasonable standard and had a layout that was conducive to the patient pathway through the unit with separation of patients' pre and post procedure. Procedure rooms were a little compact, but adequate for the purpose. The trolleys used to transport patients and accommodate them during procedures were adjustable and suitable to be used during a range of procedures.
- Staff told us they had adequate equipment and supplies to meet people's needs and the equipment service was responsive to requests. When pressure-relieving mattresses were required, they were obtained quickly.
- A range of equipment we checked had evidence of electrical safety checks within the previous 12 months in line with requirements.
- Emergency resuscitation trolleys were checked daily and there was a record of checks on each ward. However, the trolleys were unlocked and there were no security tags on the drawers to alert staff to tampering with the contents. This meant there was the possibility of unauthorised access to equipment and disposables and the increased possibility of items being taken from the trolleys and not replaced. We found the contents of the trolleys varied from ward to ward, they were frequently disorganised and additional items were found on some trolleys, making it more difficult to locate the essential items quickly.
- We asked staff about the location of emergency drugs and found staff were unsure. Some, after hesitation, said they were kept in the locked treatment room whilst others told us the emergency resuscitation team brought the drugs with them. This uncertainty gave us concerns about the ability to access the drugs quickly in an emergency. A student who had been on one of the medical wards for four weeks was unaware of the location of the resuscitation trolley.

Medicines

- The introduction of an automated medication dispensing system within AMU helped with medicine stock control, accurate dispensing of medicines and included specific safety features. For example, the system provided electronic calculations for high risk medicines to help support correct prescribing.
- The electronic prescribing system meant that medicines could be ordered online in AMU direct from pharmacy without the need for the medicine chart to leave the ward. This helped to reduce the amount of missed doses of medicines.
- Medicines were stored safely behind locked doors, which were only accessible to appropriate staff. The introduction of a new electronic key system had greatly improved the overall storage and security of medicines.
- When doctors prescribed medicines on the wards and wrote them on the medicines administration charts, they initialled the entry, but frequently did not provide any additional details, which was required, such as their name, bleep number, professional identity number or their designation. These are required to ensure an authorised prescriber has prescribed the drugs.
- A regular ward based clinical pharmacist and technician based service ensured that patients' prescribed medicines were reviewed and checked by a pharmacist.
- No checks were made of the temperature of the rooms used to store medicines to ensure they remained within recommended limits. However, the temperature of the refrigerators where medicines were stored was completed daily.
- Storage and availability arrangements of emergency medicines required for resuscitation did not follow the guidance from the Resus Council (November 2016). There were no robust arrangements in place to manage the risk and ensure that medicines for resuscitation were protected from tampering. (Intravenous fluid bags, pre-filled syringes of adrenaline, atropine and amiodarone were stored on an open and accessible resuscitation trolley). We escalated our concerns about this at the unannounced inspection however, action was not taken to remove the medicines prior to the announced inspection.

- We observed medicines administration on most medical wards and saw staff wore a tabard to highlight they should not be interrupted. We observed good practice generally in relation to medicines administration. However, we observed a member of staff on ward D16, leave the medicines trolley unlocked and unattended on one occasion when a patient called and required their oxygen adjusting.
- There were no competency checks for medicines administration in place for agency staff and staff relied on the agency nurses telling them whether they were able to administer intravenous medicines. A matron we talked with said she observed medicines administration when she was on the ward and had counselled an agency nurse who gave patients medicines without checking patient's wristbands. Therefore, although formal checks were not in place, senior staff were alert to issues. A proactive approach would be more appropriate.
- The trust had identified gaps in the medicines administration records for some patients through audits, leading to queries as to whether the medicines had been omitted, or whether they had been given but not signed for. As a result, staff were asked to check medicine records at the end of each shift to ensure they identified errors prior to the member of staff leaving the ward.
- The drug charts had a small section for recording allergies, however, this was not clear. Allergies were also recorded on the patient information system. A pharmacist told us they were currently auditing recording of allergies, however, audit results were not available at the time of the inspection.
- During the inspection we identified some pharmacy staffing concerns in the oncology day unit. The management of oncology medicines and chemotherapy is a specialised service and the potential for any errors are serious for patients. The service was using mostly locum pharmacists and although one of the locum pharmacists working at the service was experienced, others were less so and therefore the risk of errors occurring was increased. The Chief Pharmacist explained that due to recent changes and a new proposed service there had been some ongoing difficulties in resolving the staffing issues. However, following the inspection they informed us that they had obtained agreement with a neighbouring trust, which would provide two permanent specialist pharmacists to support and deliver a safe service.
- Staff reported drug errors through the incident reporting system. We were told of an incident where the on call team prescribed an anti-coagulant medication when the medical notes stated in capital letters the patient should not be prescribed the medicine due to the risk of bleeding. This gave us concerns staff may be prescribing medicines without the full information about the patient.
- An extravasation kit was available within the oncology day unit to ensure prompt action could be taken if intravenous chemotherapy medication leaked into the surrounding tissues. Extravasation is the unintentional leakage of intravenous (IV) potentially damaging medications into the tissues surrounding an infusion site.

Records

- Records were stored on the wards in lockable trolleys and on most occasions when we checked, trolleys were locked when unattended. However, some patient information was stored electronically and we found some staff had not logged off when they left computers unattended and confidential patient information was accessible. We also found medical and nursing staff printed patient information lists from the computer and we found these on surfaces near the nurses' station. They were not marked confidential.
- Staff told us they had problems in the oncology day unit with the availability of patient records when they were needed. The records were taken from the unit to enter them on to the electronic records system and they were not returned in a timely manner. As a result, treatment was delayed or had to be deferred. We were told this had been documented on the risk register but it was not on the risk register for medical services provided by the trust.
- The multi-disciplinary team made entries in the main patient record and the profession of the staff making the entry was clear. Care records were completed legibly, dated, timed and signed and the designation of the person making the entry was recorded.
- Medical staff completed an admission assessment using an assessment template when the patient arrived in AMU. The completion of these was variable in that key

information about the person's past medical history and the results of their physical examination were completed, however, some sections such as mental state and the sepsis pathway were less frequently completed. All of the records we reviewed contained a clear plan for the patient's treatment.
- There was a contemporaneous record of the patient's progress and evidence of daily review of the patient by junior medical staff
- A nursing risk assessment booklet had been completed for each patient and these included an assessment of each person's nutritional risk, their risk of developing pressure ulcers, and falls, and a moving and handling assessment. When bed rails were in place, a risk assessment had been completed to ensure they could be used safely. However, risk assessments were not always completed within 24 hours of admission on ward D5.
- Nursing care plans were pre-printed documents, most of which had not been personalised for the individual patient, and therefore some important information was sometimes missing. For example, a patient's pressure ulcer care plan did not indicate how frequently they should be assisted to move their position and a diabetes care plan gave no patient specific information relating to the management of the patient's diabetes on ward D5
- Staff completed two hourly comfort rounds for vulnerable patients. We saw records of this and when staff had assisted patients to move their position. When a patient had a urinary catheter, staff completed documentation relating to the catheter and batch number as required. A patient had two pressure ulcers and staff had completed wound assessments to monitor the progress of healing of the wounds.

Safeguarding

- The trust set a target of 95% for completion of mandatory adult safeguarding training and within medical services at the hospital, 99% of staff had completed the training as at 7 March 2017. 99% of those requiring level 1 training had completed it and 91% of staff requiring level 2 training were compliant.
- Staff were aware of the signs of abuse and told us they would report any concerns to the nurse in charge. They said safeguarding concerns were referred to the safeguarding team for the trust. The safeguarding team led the investigation and supported the staff who made the report.
- There were 590 safeguarding referrals for the trust between February 2016 and March 2017. We did not have figures for medical services alone. No cases of female genital mutilation were reported.

Mandatory training

- The trust set a target of 95% for completion of mandatory training. Overall, the completion rate for staff within medical services at the hospital was 90% as at 7 March 2017.
- The lowest levels of completion for individual subjects were resuscitation (basic life support) with 68% of staff completing this, blood transfusion with a completion rate of 77%, infection control with a completion rate of 80% and medicines management with a completion rate of 81%. Completion of moving and handling training was only slightly higher at 83%.
- When looking at compliance with mandatory training by ward, wards D11, D15 and D16 had the lowest levels of completion in the subjects, which had overall low completion levels.
- The trust said they were making changes to the resuscitation training to increase the number of staff completing the training and expected to be able to meet the target by October 2017.

Assessing and responding to patient risk

- The trust used the national early warning score system (NEWS) was used as a tool for identifying deteriorating patients. This was calculated automatically when staff entered patient vital signs observations onto the electronic observations recording system. It was possible to change the trigger parameters for escalation of NEWS to take account of the health conditions and needs of individual patients.
- The trust had previously identified that vital signs observations were not being completed in a timely manner and had introduced a monthly observation chart audit to monitor this. In January 2017, no medical wards achieved the trust target of 100% and five of the eight wards scored under 90%. Wards D16 and D26 were the two lowest scoring wards, achieving 79% and 73% respectively.

- Staff were aware of the action to be taken when a patient deteriorated and their NEWS rose. They told us they received a prompt response from the medical staff and the emergency response team or critical care outreach team.
- We looked at the records for two patients whose NEWS rose and found there was evidence of the input of a junior doctor for one patient and the emergency medical response team for the other patient. However, the trust did not monitor the escalation pathway and whether patients were reviewed within the agreed timeframe when their NEWS rose.
- Staff showed an awareness of the signs of sepsis and the need to ensure patients with possible sepsis received antibiotics within an hour of arrival. Posters relating to the "Think Sepsis" campaign were displayed in the AMUs.
- Patient records we reviewed showed staff identified sepsis on admission, ordered a range of investigations, and initiated treatment. However, the sepsis pathway documentation was frequently not completed. The pathway documents ensure a systematic approach was taken and all necessary investigations and treatments were completed in a timely manner.
- Staff were less familiar with the acute kidney injury guidelines and the care bundle was not being used at the trust. There was a lack of visible advice about AKI care pathways. Although AKI guidelines were available on the intranet, staff had difficulty in finding it. Acute kidney injury (AKI) describes a sudden reduction in the function of the kidneys and can occur as a result of an illness or infection which has resulted in a drop in the patient's blood pressure or a reduction in their fluid intake. More severe kidney injury is classified as grade 2 or 3.
- A consultant said they would ring their renal colleagues for advice in the case of AKI, although we were told only patients with AKI grade 3 were referred directly to a renal consultant. National standards on AKI (NICE QS76) state that people with acute kidney injury should have the management of their condition discussed with a nephrologist as soon as possible, and within 24hours of detection, if they are at risk of intrinsic renal disease or have stage3 acute kidney injury or a renal transplant.
- The trust provided a copy of an audit that had been completed between April 2016 and September 2016 to assess staff compliance with national guidance on AKI produced in 2013. However, the NICE guidance was updated in 2014, therefore the audit did not take account of the up to date guidance. The recommendations from the audit included a robust training programme for junior doctors in accordance with "Think Kidney" guidelines. Staff we spoke with were unfamiliar with the "Think Kidney" guidelines.

Nursing staffing

- We reviewed nurse staffing data provided by the trust for January and February 2017. These indicated that planned staffing levels had been achieved for most shifts for all weeks apart from one week in February on ward D16.
- The nursing vacancy rate for medical services at the hospital was 7.6%, however there were considerable differences across individual wards, with the highest vacancy levels being for D11 at 24%. The percentage of temporary staff used in December 2016 was particularly high on wards D15 and D16 at 29% and 24% respectively.
- Nurse staffing levels were primarily based on a ratio of registered nurses to a number of patients alongside professional judgement. The trust had previously used a recognised tool to assess staffing and skill mix requirements and they were considering the value of utilising this again in the future.
- The nurse staffing requirements of some of the medical wards were reviewed and had been increased within the last six months and staff on those wards told us they felt the staffing levels allowed them to meet the needs of the patients they cared for.
- On ward D26, we were told the staffing levels had been increased and would be reviewed after three months, although the staff were unclear as to the criteria for the review and how the decision would be made. They told us the number of patient falls had decreased since the addition of more staff.
- During the unannounced visit we were concerned about the staffing levels on ward D15 and we noted the number of beds had been increased from 18 to 24 for some time. We were told recruitment and retention of staff was an issue and sickness absence was high and this was reflected in the data we received from the trust for February 2017. Staff were struggling to attend mandatory training and it was frequently completed by staff outside their working hours.

- When we returned for the announced visit, we found the number of beds had been reduced to 18 and in the completion of mandatory training had improved. A business case had been submitted to increase staffing levels further.
- During the announced inspection, we identified concerns with nurse staffing levels and skill mix on ward D16. Although, the trust had made the decision to close additional beds which had been open on the ward, staff vacancies, sickness absence, and a number of patients requiring one to one care, resulted in the continued high usage of agency staff. In the previous week, there had been three days when only one permanent registered nurse was on duty and the other registered nurses were agency staff. Similarly on night shifts there was frequently only one permanent registered nurse on duty.
- Compliance with the targets for the timely completion of vital signs observations were low, attendance at mandatory training was well below trust targets and completion of staff appraisals were low on ward D16. 40% of registered nurses and 57% of other clinical staff had had an annual appraisal as of 1February 2017 on ward D16.
- Agency nurses were not provided with a formal induction. A matron told us there was a checklist for staff to go through with agency staff, but we found it was not being used consistently. An agency nurse told us they were given a tour of the ward, the routine was explained and they attended handover.
- A patient expressed concerns about the high use of agency staff on ward D16 and other patients on the ward talked about a shortage of staff which contributed to delays in staff providing basic care. A patient said the timing of medicines was haphazard and they were sometimes not assisted to have their daily wash until 3pm. They told us of a time when they had rung their call bell as they needed to go to the toilet. They said, "I waited and waited and nothing happened." They told us they had used their mobile phone to telephone the switchboard operator and the operator rang the ward but did not get an answer. They said the switchboard operator rang the duty manager and they came to the ward. They then received a commode very quickly. The patient said most of the permanent staff were excellent but said, "I am sad that such a wonderful ward is being brought to its knees."
- Another patient said staffing at night was reduced and, "You only see them if you call."
- A consultant we talked with said that staff were unable to attend ward rounds on D15 and D16 as staffing levels did not allow this. They said they had developed "work arounds to ensure the necessary information was communicated.

Medical staffing

- The vacancy rate for medical staff within medical services at the trust was 13.3% and medical turnover was 11% on 1 February 2017. We were not able to obtain rates for the city hospital site specifically. This was because some specialties were multi-site appointments whilst others were based at only one site.
- Out of 12.5 WTE (whole time equivalent) consultant posts across the AMUs in the trust there were four permanent consultants in post, four locum consultants and four vacancies.
- There was a slightly lower percentage of consultants and middle grade doctors in medical services at the trust in comparison to the England average and a slightly higher percentage of junior doctors and registrars.
- Consultants were available on the AMUs from 8am until 7pm. The on-call medical consultant attended a 5pm ward round on AMU to ensure they were aware of any patients not seen by the acute medicine consultant. The on-call consultant was trained in general medicine or acute internal medicine and was able to reach the unit within 30 minutes.
- Advanced nurse practitioners (ANPs) were utilised within AMU to contribute to junior medical staffing levels at night.
- Arrangements for consultant cover during annual leave were inconsistent. The consultant caring for patients on ward D26 was on annual leave during the week of the inspection and there were no arrangements for consultant led ward rounds during their leave. As a result, decisions relating to the patients' care and discharge may not have been made in a timely manner.
- The respiratory consultant covering wards D15 and D16 during the inspection was not present at board rounds during the inspection.
- We noted a locum respiratory registrar had not attended for three consecutive days but staff were unaware as to whether this had been escalated.

Medical care (including older people's care)

- In cardiology consultants, carried out board rounds at weekends. However, in some other specialties, consultants provided on call cover only.
- Junior medical staff were based on wards from 8.45am to 4.45pm weekdays. Junior doctors and ANPs provided cover for all medical wards at night. Junior doctor rotas complied with the trainees' contract for 2016 and the trust told us they had been slightly modified from August 2017 to comply with the new contract. Junior doctors told us they were busy and could be stretched, but the workload was manageable.

Major incident awareness and training

- The trust had a Major Incident plan. This was reviewed and implemented from April 2016. Staff were aware of the plan and how to access it.
- Fire safety warden and fire safety team leader training was provided for the senior ward sisters. We noted some senior ward sisters had completed it, but not those on ward D11, ward D15 and ward D16.
- We noted a fire evacuation plan was displayed on wards.
- A Business Continuity Plan was also in place and dated April 2016.

Are medical care services effective?

Requires improvement

We rated effective as requires improvement because:

- The requirements of the Mental Capacity Act (2005) were not well understood and applied. There was confusion amongst staff in relation to the Act and the Deprivation of Liberty Safeguards (2007).
- Documentation of patients' fluid intake was poor; therefore, we could not be confident patients staff assisted patients to consume adequate amounts of fluids.
- There was variability in the attendance at multi-disciplinary board rounds and ward rounds and therefore in the effectiveness of multi-disciplinary communication.
- Seven day working was not fully established and there was variability as to whether consultants reviewed patients at weekends.
- Access to information through the trust IT system was slow and made more challenging by the requirement to use a variety of systems for different parts of the patient's care.

However:

- Clinical outcomes for patients within cardiology were in line with or better than the England average.
- Patients' risk of malnutrition was assessed and patients were referred to a dietician for advice when they were identified as being at high risk.
- Junior medical staff had access to training and felt well supported. Development programmes were available for nurses and a practice development nurse was available for cardiology.
- A new IT infrastructure including a new electronic patient record, was due to be implemented and expected to be complete by the end of 2017.

Evidence-based care and treatment

- Staff were aware of National Institute for Health and Care Excellence (NICE) guidance relevant to their specialty and had access to the guidance via the trust's intranet.
- Local protocols and guidelines were in place and were based on NICE guidance. The guidelines we reviewed were up to date.
- The service participated in national and local audits to assess compliance with NICE guidance. For example, the national audit of cardiac rhythm management (NICE TA88, TA324 and TA314), NICE Clinical Guideline (CG141) and Quality Standard (QS38) for Acute Upper GI Bleeding, and Acute Coronary Syndromes in Adults (NICE QS68). The services produced action plans to address areas of non-compliance with the guidance and we saw evidence of progress against these.
- The service did not make widespread use of care pathways and protocols on the medical wards. However, we noted some pathways were used in some specialties such as cardiology where pathways were used to guide treatment of patients admitted with a heart attack (NSTEMI and STEMI pathways) and staff told us other pathways were in use for cirrhosis of the liver.
- Care pathways were in place in the ambulatory medical assessment area for a wide range of conditions from chest pain and headache to syncope and upper GI bleeds.

- Dementia and delirium care pathways had been introduced but we did not see them widely used during the inspection.
- Staff were aware of the sepsis care pathway, although did not always complete the pathway documentation in the admission assessment documents.
- Guidelines for the diagnosis and treatment of acute kidney injury (AKI) were available on the intranet, however staff were not conversant with these.
- All patients on AMU were reviewed by a Consultant at least twice daily.
- Once transferred to the medical wards, patients in most specialties were reviewed at a consultant led board round or ward round daily during the week. However, consultant led wards rounds did not take place daily and we were told by consultants their job plans required them to undertake ward rounds twice a week.
- During the inspection we noted there was not always a consultant present at board rounds and we were told a respiratory consultant regularly did not attend board rounds.
- Patients we talked with said they did not see a consultant daily and a patient record we reviewed indicated a patient had not been reviewed by a consultant for four consecutive days.

Pain relief

- Staff asked patients about their pain and recorded pain scores with the vital signs observations.
- Most patients told us staff provided prompt pain relief medication when they required it and their pain was controlled well. However, one person told us they had waited one and a half hours for pain relief on one occasion during the night on ward D16 and asked the staff three times before they were given anything.
- The trust reported results of pain audits on the monthly quality, safety and patient experience dashboard and all the medical wards at the hospital scored 100% in January 2017 except ward D16 which scored 80%.

Nutrition and hydration

- Staff completed nutrition screening when patients were admitted and repeated the screening on a weekly basis.
- The trust completed monthly audits to assess the percentage of patients who received nutritional screening within 24 hours of admission. In January 2017 only two medical wards at the hospital (ward D26 and ward D7) achieved 100%. Scores ranged from 69% and three wards did not meet the trust target of 90% (ward D5, ward D11 and AMU1).
- We saw evidence that staff referred patients to a dietitian when they identified them as being at high risk nutritionally.
- Staff used a standard daily nursing care record to document patients' food and fluid intake and these appeared to be used for all patients rather than those patients assessed as needing to have their fluid intake monitored. The records were not always completed consistently or, if the fluid intake charts were accurate, some patients were not consuming adequate fluids. For example, one record we reviewed indicated the patient had consumed only 350mls in 24 hours and there was no action plan to ensure the patient's fluid intake was increased. The nurse in charge said it was most probably a recording issue and they would monitor the patient's fluid intake more closely. Patients told us they were provided with fresh water and the water jugs were changed twice a day. They said they were also offered hot drinks between meals.
- Snacks were available between meals and patients on the oncology day unit were provided with snacks which they were able to access themselves if they wished.

Patient outcomes

- The service participated in national audits to examine their clinical outcomes and compare them to other trusts.
- In the National Diabetes Inpatient Audit (2015) the hospital scored better than the England average for nine measures and worse than the England average for eight measures. The best score in comparison to the England average was staff knowledge of diabetes and the worst performance was in the percentage of patients seen by the multi-disciplinary foot care team.
- The results of the 2016 Lung Cancer Audit indicated the proportion of patients with advanced non-small cell lung cancer (NSCLC) receiving chemotherapy was 48.6%; this is significantly worse than the national level of 63.6%. The proportion of patients with small cell lung cancer (SCLC) receiving chemotherapy exceeded the levels suggested for the audit year.
- The results for the Heart Failure Audit (2015) were better than the England and Wales average for all standards relating to in-hospital care and discharge.

- In the Myocardial Ischaemia National Audit (MINAP 2014/15), the hospital scored better than the England average for all three measures.
- The trust produced action plans to address areas where performance did not meet the required standards. For example, the national clinical audit of rheumatoid and early inflammatory arthritis assessed performance against the NICE quality standards in 2016 and the trust produced an action plan to work towards those standards not being fully met. Progress was demonstrated in the results of the 2016 audit as compared to the baseline audit in 2015.
- The trust had recently started to submit data to the national Inflammatory Bowel Disease (IBD) registry to enable comparison of outcomes for patients with this disease.
- The trust compared their treatment outcomes for TB against national standards. They met or exceeded the standards for treatment completion in active and latent TB cases during 2015/2016.
- The trust failed to achieve Joint Advisory Group (JAG) accreditation for gastro-intestinal endoscopy in 2016. JAG sets national standards for gastro-intestinal endoscopy and accreditation provides assurance that a service is meeting the required standards.
- The trust had developed an action plan to gain accreditation in 2017. We reviewed the action plan and discussed it with the clinical leadership team. They felt achievement of those standards related to access and waiting times had the greatest level of uncertainty, due to increased demand for the service. However, additional consultant sessions had been introduced to mitigate the impact.
- Between September 2015 and August 2016, patients in medical services at City Hospital had a higher than expected risk of readmission for non-elective admissions and a slightly higher than expected risk for elective admissions. Risks of readmission for elective Clinical Haematology, elective and non-elective Cardiology and non-elective General Medicine were higher than the expected rate.
- The senior management team told us they had reviewed re-admission rates in depth and there were visual alerts on the electronic management system to highlight re-admission rates.
- The risk of re-admission for elective and non-elective cardiology was higher than average. The management team identified that patients on the heart failure pathway returned to hospital as part of the planned pathway and this may be contributing to the higher re-admission rate.

Competent staff

- Junior medical staff said they had a good induction and were allocated an educational supervisor. Most junior medical staff told us they were able to attend their weekly training sessions, and staff received informal training on AMU, but there was no formal clinical skills training. They felt generally well supported. We were told a new clinical skills laboratory had been developed in AMU.
- Specialist registrars had access to monthly general medicine training days and they were required to attend at least six of these each year. In addition, acute medicine training was provided on a monthly basis for which 80% attendance was required.
- Nursing staff had access to internal training and some externally provided courses although access to training was felt to be difficult in some areas, due to the impact on staffing levels.
- We talked with two registered nurses who had qualified within the last year and they told us they had completed a preceptorship programme and met with the ward sister every three months to discuss their progress. They found their colleagues supportive and said they were not pushed to undertake additional competencies until they felt confident.
- A practice development nurse was available on the cardiology wards and worked with the nurses to develop their skills in the clinical environment. An 18 month programme was in place for newly qualified nurses to enable them to develop the specialist skills required for cardiology in a planned way.
- A management development programme was provided for senior ward sisters and those we talked with spoke about the benefits of this in developing their management knowledge and skills.
- 84% of staff within medical services at the trust had an appraisal between April 2016 and March 2017. When broken down by profession, 95% of medical staff had an appraisal in the same period.
- 88% of registered nurses in medical services at the hospital had an appraisal. Staff told us they found their appraisals constructive and enabled them to identify further development needs.

- Patients generally told us they had confidence in the knowledge and skills of the staff caring for them. However, a patient on ward D16 told us they felt some of the agency nurses on the ward were not competent or experienced in the ward specialties. They told us of times when they had needed to correct an agency nurse to prevent mistakes occurring. They said most of the permanent staff were "Superb, observant and well organised," but the number of agency nurses used meant it was difficult for staff to supervise them.

Multidisciplinary working

- Staff told us multi-disciplinary team work was good and most staff said the different professional groups communicated well with each other. However, we observed variability in communication at ward level and variability in the way multi-disciplinary processes were delivered.
- We found there was variable attendance at daily board rounds, which are an important tool to facilitate multi-disciplinary communication and effective care planning. Some daily board rounds had good attendance and there was good multi-disciplinary attendance but others were attended by only nurses, junior doctors and an allied health professional.
- We saw evidence in patient records of the involvement of dieticians, physiotherapists, occupational therapists, speech and language therapists, pharmacists and specialist nurses in addition to medical staff and ward nurses.
- When patients required a referral to another specialty within the trust, different referral processes were in place. Paper forms were used for some specialties whilst referrals were made to other specialties by bleeping the on call doctor.
- A complex discharge team was in place and a member of the team attended some ward rounds. They received referrals by word of mouth and by attending the "Red to Green" daily meetings which were held to review patient progress and delays to discharge.
- Cardiology held weekly MDT meetings with cardiac surgeons at two neighbouring hospitals to discuss patients requiring cardiac surgery. These were attended by junior and senior medical staff from cardiac medicine and surgery.
- There was a lack of oncology review of patients on the medical wards and oncology attendance at MDT meetings.

Seven-day services

- A team of six physiotherapists covered the medical wards during the week, excluding respiratory patients for which there was a specialist team. Three duty physiotherapists were available at weekends. Wards held meetings on a Friday afternoon to identify patients who required physiotherapy over the weekend or discharge planning for a weekend discharge.
- Pharmacists visited the medical wards weekdays during the morning, and they were supported by a team of ward-based pharmacy technicians helping to deliver prescription screening, medicines reconciliation, and drug supply throughout the patient visit and at discharge.
- Pharmacy was open between 9am and 5.30pm Monday to Friday, from 9am to 12.30pm Saturday and from 10am to 1.30pm on Sunday.
- Daily ward rounds were carried out by the on-call medical consultants on AMU at the weekend and an on-call consultant visited medical patients who required a review on other wards.
- A cardiology on-call consultant visited the cardiology wards at the weekend and carried out a board round, reviewing patients as necessary. An on-call consultant was available for other specialties but they did not carry out ward or board rounds at the weekend.
- Imaging was available for patients classified as urgent at the weekend.

Access to information

- Staff expressed general frustration with the trust IT system which was slow and unwieldy. We were told, "Something goes wrong every day," and, "It took me two hours for (the patient administration system) to power up the other day."
- The discharge system produced discharge letters and a list of medicines to take home but did not link to pharmacy, so the list was printed out and taken to pharmacy.
- The trust was in the final stages of implementing a new IT infrastructure including a new electronic patient record and this was expected to be complete by the end of 2017.
- Staff also told us they had difficulties in obtaining patient records from the medical records library. In the oncology day unit they experienced difficulties with the availability of patient notes when patients attended. We

were told 13 out of 17 patient notes were missing at a clinic the previous week. Staff said this could affect decisions about treatment and they had reported it on the incident system.
- Discharge letters were produced on the electronic system and sent to the GPs. This gave a summary or the care and treatment the patient received. A copy of the discharge letter was sent home with the patient. The discharge letter contained information about the patient's medicines on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff asked their permission before giving care and treatment. They said staff respected their choices and provided enough information to enable them to make decisions about their care.
- We saw consent forms had been used to document consent for clinical procedures and these were signed by the patients.
- However, there was no documentation of consent for the use of bed rails when these were in place, or a mental capacity assessment and best interest decision if the person was unable to consent. We would have expected to see that patients had consented to the use of bed rails or, if the patient did not have the capacity to consent, a mental capacity assessment and best interest decision to be documented.
- A patient refused a pressure relieving mattress used to prevent the development of pressure ulcers and staff documented that they had explained why it was needed and the patient understood the implications of their refusal.
- Staff knowledge of the implications of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) on decision making was variable and there was a lack of understanding of the difference between mental capacity and deprivation of liberty.
- Care records for some patients who lacked capacity to make some decisions for themselves did not contain a record of a mental capacity assessment or any evidence of how decisions had been made in relation to the care and treatment which had been provided. Therefore, we could not be sure that the patients' rights had been protected.
- A DoLS application was made for a patient who was living with dementia and, according to the application, lacked capacity. There was no mental capacity assessment and there was inadequate information in the application to enable anyone reviewing the application, to know whether or not a DoLS was required. There was no information about the restrictions being put into place or the fact that the patient was refusing some aspects of care.
- However, at a MDT meeting on another ward, the requirement for an ongoing DoLS authorisation was reviewed and staff demonstrated an understanding of the issues.

Are medical care services caring?

Good

We rated caring as good because:

- Patients on most wards told us staff were kind and patient towards them and other patients on the ward.
- We observed staff were attentive towards patients and demonstrated an understanding and empathy for patients.
- Most patients told us they had received good explanations about their care and they felt involved in their care. They felt able to ask questions and their questions were answered in a way they could understand.

However:

- We received some feedback from patients on ward D26 that a minority of staff were uncaring and rude to patients who were vulnerable.
- We observed an occasion when a nurse did not provide an explanation to a patient when they took their blood pressure and we saw a nurse whose tone of voice was abrupt and short when talking to a patient.

Compassionate care

- We observed nurses who were attentive to patients and they interacted with patients in a professional and respectful manner.
- When we spoke with staff they demonstrated a commitment to patients' wellbeing and empathy for them. We observed a patient shouting at a nurse and being quite rude to them. The nurse was very patient and apologised when they had not done anything to

warrant the patient's behaviour. However, we also observed a nurse responding to a patient who was calling for a nurse repeatedly; the tone of the nurses' voice was abrupt.

- Patients on most wards told us staff were kind and caring. One patient said in relation to the way staff behaved with vulnerable patients, "They are never rude. They are so patient; I wonder where they get their patience from." Another patient said, "They treat you really well. We all have a laugh." "They help the elderly and those who can't do things for themselves."
- The relatives of a patient living with dementia said the care on AMU was, "First class." They said, "There was nothing they [staff] wouldn't do. They handled everything brilliantly."
- However, on ward D26 a patient told us about occasions when staff had responded to a patient's call, but had not dealt with their care need and then ignored the patient. They went on to say, "Staff are generally lovely but there are a few rogue staff." "I have heard a bit of rudeness and racism [from staff] but how do you stop it?" We informed the senior management team of these comments.
- A relative of a patient on ward D26 said, "The caring aspect has been lost." They went on to say, "Nurses at night are less caring and ignore [the patient]. They tell [the patient] to stop pressing their buzzer," Some of the HCAs are rude but not abusive. They raise their voices and [the patient] is not deaf."
- Staff used, "Do not disturb" or "Please respect my privacy" notices clipped to curtains to ensure they were closed and to discourage interruptions when the curtains were pulled around patient's beds.
- We noted there was widespread use of hospital gowns. These were open at the back and could be tied at the top, but they did not wrap over and often gaped at the back, exposing patients when they mobilised. Staff were alert to this and acted to cover the person when they saw it, however, gowns that fastened differently could have prevented this occurring.
- In relation to privacy and dignity, a patient said, "I would give them an A* for that." Another patient said staff mostly protected their privacy and dignity, but said on one occasion, "I was sitting on the commode and the [male] cleaner waltzed into my bed space and took my meal tray. When I complained he just giggled. So I complained to the nurse in charge. The nurse asked him to apologise to me, but he just giggled again."
- A patient complained to us about the attitude of a consultant when discussing their discharge arrangements and when they disagreed about their future care arrangements. They said they felt bullied and that "Consultants have to accept they are not Gods."
- Medical services at the hospital had a response rate for the national Friend and Family Test (FFT) between January and December 2016 of 25%. This was in line with the England average.
- The FFT asks how likely patients are to recommend the ward to the family and friends. Scores were lower for some wards between May 2016 and October 2016 than in other months of 2016. Ward D11 scored less than 75 for more than three months of the year and ward D15 scored less than 80 for five months of the year. Ward D16 did not reach the response rate at which results are reported, for seven months during 2016.

Understanding and involvement of patients and those close to

- Staff did not always explain what they wanted to do in order to gain patients' cooperation. On one occasion, we observed a member of staff go to a patient and start to take their blood pressure without explaining what they were doing. They said, "Put your arm up," to the patient. The member of staff was unfamiliar to the patient and the patient asked another member of staff they recognised what the person was doing. However, most of the time we saw staff explaining and gaining the person's understanding and cooperation prior to providing care.
- Most patients were very positive about the provision of information and were clear about the plan for their care. For example, a patient told us they were given different options for their treatment. They said the medical staff were aware of their concerns about some of the treatments and took this into account. They also said that on a previous admission they had a cardiac arrest and their close relative was very impressed with the information provided by the medical staff and the way they kept them informed.
- Another patient said they felt able to ask questions. They said they had a new condition and they had been given lots of leaflets to read. They said they had been involved in their treatment and care and they were expecting to go home that day.

Medical care (including older people's care)

- A patient told us that if a nurse did not know the answer to a question they would find someone who did know, or would ask the doctor to speak to them.
- A relative who had power of attorney for a patient, said they were fully aware of the plans for their relative's care and treatment. They said, "When the doctors see we are visiting they make sure they come and have a chat with us. Their relative's health was failing and they said, "We have had an open and honest conversation with the doctors."
- However, other patients were less clear about the plan for their care and felt less informed. A patient said "The doctor this morning said it would be a couple of days (before discharge), but I don't know what I am waiting for." Another patient said, I don't know what the plan is, I have just given up."

Emotional support

- When patients showed signs of distress or anxiety, staff spent time with them and tried to provide reassurance. A patient said, "I was very anxious when I first came in and they got the doctor up to see me and reassure me." Another patient said they had been upset the previous day and someone came and sat with them and talked with them until they felt better.
- Visiting times at the hospital had been extended and families were able to stay outside visiting times at the discretion of staff. We saw families were able to stay with patients when the patient was living with dementia, had a learning disability, when they did not speak English, or when they were very unwell. This reduced patient's anxiety.
- However, a patient with cancer said they had not been offered any emotional support.
- The hospital chaplains and chaplaincy volunteers undertook pastoral visiting to the wards.

Are medical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- We found a range of factors that negatively impacted on the patient journey from admission to discharge including delays in obtaining medicines to take home (TTOs), and transport issues. There was a lack of consistency in multi-disciplinary processes such as board rounds and ward rounds.
- The overall progress of patients was hampered by delays in obtaining blood results and delays in diagnostic investigations.
- Processes for referring patients to other specialties or members of the multi-disciplinary team were variable and could lead to delays in the patient journey.
- Patients were frequently moved from one ward to another after 10pm in the evening and a number of patients were moved between wards during the day for non-clinical reasons.
- The AMUs were utilised to provide care for patients when there were not appropriate skills or bed capacity elsewhere in the hospital. This meant that patients had reduced access to the specialist teams and may have impacted on length of stay.

However:

- The trust were implementing an ongoing programme to improve patient flow, timeliness of discharge and reduce length of stay. This encompassed eight work streams to tackle issues including factors contributing to delays to discharge, timeliness of access to diagnostics, and clinical team working.
- Adaptations to the environment on some of the wards made them more suitable for patients living with dementia. The hospital had appointed an activities coordinator to provide therapeutic activities particularly for people living with dementia and those with complex needs.

Service planning and delivery to meet the needs of local people

- A cardiology community project provided a focus on heart failure. Cardiac rehabilitation nurses held awareness events and focus groups in local temples to reach, and make advice accessible to, ethnic minority groups in the local population.
- A trial of a seven day service for patients with chronic obstructive pulmonary disease (COPD) was initiated to reduce repeated admissions for patients with this long term condition. The trial ended due to a shortage of specialist nurses, however, due to the success of the service, staff were being recruited to enable the service to be re-instated.

- The trust had developed a homeless patient pathway to ensure care continued after acute treatment. It recognised the need to help treat mental health and social illness alongside acute illness for this group of patients. The trust worked with other health providers and partners in the local area to offer help and support for the homeless. Early statistics showed that the pathway had reduced readmission rates for patients who had been frequently admitted to hospital.
- The senior management team were reviewing the number of medical beds and capacity for each specialty by looking at demand, in preparation for moving to the new hospital, which will be called The Midland Metropolitan and due to be opened in October 2018.

Access and flow

- In January 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services was the same as the England average of 91%. Rates rose above the average in February to 95%, however, between March 2016 and December 2016 the trust's referral to treatment time was worse than the England overall performance. The latest figures for December 2016 showed 88% of this group of patients were treated within 18 weeks versus the England average of 90%. Rates were relatively stable over the period.
- When examining this data by specialty, the percentage of patients admitted within the 18 week RTT was worse than the England average in neurology, dermatology, thoracic medicine and gastroenterology.
- Medical patients were normally admitted via one of the two acute medical units (AMU1 and AMU2). AMU1 incorporated an ambulatory medical assessment area which provided assessment, diagnosis, treatment and discharge, or onward referral, for medical patients who did not require an overnight stay.
- The ambulatory medical assessment area was staffed by advanced nurse practitioners with access to medical staff when requested. Consultant cover was provided by the on-call acute medicine consultant or the general internal medicine consultant. Care pathways were in place for a range of conditions which were treated within the area.
- There was also a consultant led virtual clinic for patients following discharge from AMU, where medical plans could be communicated directly to patients and their GPs by letter or telephone without the need for a formal outpatient appointment.
- AMU2 incorporated the West Midlands Poisons Unit which provided care and treatment for a small number of patients (usually no more than four at any time), under the care of the toxicology team.
- A consultant we spoke with told us they felt there was enough capacity in the AMUs and patients were generally able to be transferred to other wards without undue delay. However, staff told us male cardiology patients frequently had an extended stay in AMU, as there weren't sufficient cardiology beds on the male cardiology ward. A consultant said that up to a third of patients in AMU at any one time, might be waiting for a cardiology bed after they had been accepted by the duty cardiology medical team. On the day of the unannounced inspection, two of the three patients we talked with on AMU1 were waiting for a bed on the male cardiology ward.
- The number of cardiology beds in the trust had been reduced in preparation for the move to the new hospital. The senior management team said the decision on the number of beds required, was based on the number of admissions to cardiology and that, although there were occasions when the demand exceeded capacity, it was not a frequent occurrence. We asked the trust to provide us with the numbers of cardiology patients who stayed in AMU1 for more than 24 hours, however, they did not provide this information.
- The trust held capacity meetings at 8am daily and at intervals throughout the day, the frequency depending on the bed situation within the trust.
- There was a lack of single rooms for the care of patients with a suspected or confirmed infection within the hospital. Six side rooms were available on the acute assessment units (AMUs) with two rooms having negative pressure ventilation on AMU1. However, other medical wards had few side rooms and there was no isolation unit/ward. As a result, patients with infections remained on AMU for an extended period and some patients who were identified as having an infection later in their stay, such as those with active TB or C. difficile (C. diff), were moved back to AMU in order to provide single room facilities. This meant that patients were not ideally placed for their condition and AMU was not utilised as effectively as it could be.
- Patients requiring non-invasive ventilation (NIV) were cared for on the AMU and NIV was initiated by the critical care outreach team. The respiratory wards only accepted patients on domiciliary NIV or those who were

very stable. This impacted on the optimal use of AMU beds and patients requiring NIV were cared for primarily by the acute medicine consultants rather than respiratory consultants.

- A frailty score was not used to assess patient frailty although some education was provided for medical staff on frailty. There was a frailty unit at the neighbouring hospital within the trust but no frailty unit or specialists within the hospital.
- Between January 2016 and December 2016, the trust reported 3,386 patients at the hospital moved ward two or more times. This amounted to 7% of the total number of admissions. Two per cent of patients moved wards more than twice. Moving wards for non-clinical reasons can disrupt the continuity of care and increase length of stay.
- 86 patients in medical services were moved after 10pm during January 2017. A similar number of patients were moved after 10pm in November and December 2016. Moving wards at night is potentially distressing for patients and disorientating for those with cognitive impairment
- A consultant led ward round occurred twice daily on AMU. We observed the morning handover which was well attended and followed a standard format. Each new patient and patients with ongoing problems were discussed at the handover, which was led by the oncoming consultant.
- Morning Board rounds were completed daily on most wards during the week, however, consultants were not always present. Consultant ward rounds were carried out twice weekly on most wards.
- The overall progress of patients was hampered by delays in obtaining blood results and delays in diagnostic investigations, although it was unclear whether the delays were in the requesting process or waits for the investigations themselves. For example, a patient was screened for suspected myeloma on 24 March 2017 and the results had not been seen on 27 March. On the 28 March the blood results were received and were suggestive of myeloma but a spinal CT scan had not been done when we checked on 29 March.
- Staff told us that if a patient needed an urgent scan at the weekend they were carried out but scans which could wait until the following Monday, were done during the week.
- Patients talked about delays in investigation. A patient's relative said, "We are waiting for a scan; there is a queue." "On Saturday we were told they [the patient] needed a scan; they [staff] have done x-rays but we are waiting for a CT and then a camera." This conversation occurred on Wednesday the following week.
- A consultant oncologist told us there was also a backlog of CT scan reports.
- The trust said CT scan appointments were within 24 to 48 hours for inpatients and reporting was within 24 hours for inpatient and emergency CT scans, within one to three days for urgent outpatient scans and between three and 14 days for routine CT scans. These timeframes were within the national guidelines.
- A programme to improve patient flow, timeliness of discharge and reduce length of stay was ongoing in the trust. As a result, eight work streams were identified and each was being taken forward by a team within the trust.
- One of the work streams was to improve the timeliness of access to diagnostics. This included education for staff to ensure appropriate requests, a triage system, and changes to the pathways for inpatient echocardiograms. Staff were also given access to the booking system to enable them to see when patients were booked. The management team said patients could wait for up to four days for an echocardiogram and the work would reduce waiting times.
- Other work streams included improving the timeliness of supply of, "To take home medicines" (TTOs), patient transport, complex discharges, and ward clinical team working.
- An electronic discharge system was used which produced discharge letters and listed the TTOs. However, it did not link to the pharmacy and therefore a list was printed out and was taken to pharmacy. This increased the time taken for TTOs to be received in pharmacy.
- Staff told us there was currently a turnaround time of two and a half to three hours from receipt of the TTO in pharmacy to the medicines arriving back on the ward. The trust was working towards reducing this time to two hours.
- When patients required referral to other specialties or services, different procedures were required for each type of referral. For example, some specialties used a paper form whilst for others referral was made by bleeping the on call medical staff. We were told the referral processes could be time consuming and created delays in responses to referrals.

- Staff held a daily meeting to review progress of patients towards discharge and identify any issues which were acting as blocks within their journey.
- We received variable feedback from patients regarding discharge arrangements. Two patients told us of problems they had experienced following a previous discharge which had resulted in their re-admission. However, one patient said, "This week they [staff] have done marvels." "The social worker has been involved, there's a plan in place for when I get home and transport has been arranged, all in a matter of days."
- We found a lack of information about plans for discharge in patient records, even when patients were being discharged within the next 24 hours.
- Two wards managed by the community and therapy services directorate provided accommodation for patients who were medically fit for discharge but required ongoing care, and those requiring intermediate care. This reduced the number of patients on acute medical wards who were waiting for discharge.
- Between October 2015 and September 2016 the average length of stay at City hospital for medical elective patients at was 3.6 days, which is better than the England average of 4.1 days. For medical non-elective patients, the average length of stay was 5.2 days, which is better than the England average of 6.7 days.
- When broken down by specialty, the length of stay was slightly higher than the England average for elective cardiology (2.4 days as compared to an England average of 1.9 days). The senior management team said issues relating to timely access to investigations in the cardiac catheterisation laboratory impacted on length of stay. Changes to the time of opening of the medical day case unit were implemented to improve inpatient access to the laboratory at the beginning of the day.

Meeting people's individual needs

- Wards were designated as male or female wards and no same sex accommodation breaches were reported within the medical wards during 2016.
- We spoke with a 16 year old patient who was being cared for on an adult ward and was unhappy about it. On admission they had been very ill and were told they had to go to the adult ward as there were no acute children's services at the hospital. The patient was too ill to discuss at the time and their mother did not speak English. The staff had not discussed this again when the patient was feeling better and they told us they wanted to be on a children's ward.
- Staff completed care rounds every two hours to ensure patients received regular attention to their care needs.
- Information leaflets were readily available on each of the medical wards to provide information on a range of medical conditions and procedures relevant to the ward specialty. We did not see any leaflets in languages other than English.
- A large proportion of patients did not speak English as their first language. Staff explained they could access interpreting and translation services through ringing a central telephone number. An interpreter could be booked or a telephone interpreting service utilised. We saw a multi-user telephone handset in the consulting room in the endoscopy department, which staff were clearly confident in using.
- We did not observe the use of any pictorial communication aids to facilitate communication with patients on issues related to the activities of daily living and we saw some difficulties in communication occurring. An example of this was when staff were serving hot drinks. A nurse said they had learnt a few words of Punjabi and staff said they asked staff with skills in other language to assist on day to day communication issues.
- A learning disabilities specialist nurse was available to provide advice and support for staff and patients when a patient with a learning disability was admitted to the medical wards.
- Some staff told us they had received learning disability awareness training. They said they checked whether the patient had a hospital passport to provide additional information on their support needs and preferences.
- A member of staff on AMU2 said a patient with learning disabilities had stayed on the unit for an extended period recently, as they had frequent seizures. They said they encouraged family and carers to be involved and in this instance the family stayed overnight with the patient.
- Some staff were not able to identify any arrangements that could be put into place to support a patient with a learning disability.
- The environment on some medical wards had been adapted to better meet the needs of patients living with dementia. For example we noted the use of contrasting

colours on ward D26 contrasting colours, there were clocks in each bay, and reminders of the day and date. An informal seating area was partitioned off to provide some quiet space away from the bed spaces and with information leaflets and games.

- An activities coordinator had recently been appointed to "promote therapeutic activity." They told us they worked mainly with patients with dementia or delirium or those with no outside contacts. The majority of their time was spent on wards D11 and D26. Activities depended on the patient and their interests. For example, they offered activities such as painting, card games and other games, and used reminiscence boxes and cards. They said they also read newspapers to people or spent time chatting with them.
- We also saw examples of people involved with activities on other wards. For example, on AMU2 we saw a patient sitting at a table in the middle of the ward with an activity box. Staff interacted with the patient as they passed and we saw a member of staff playing a game with the patient a short time later.
- We observed staff distributing breakfasts and lunches. Patients were asked to choose from a menu for lunch the evening before. A patient who required a Halal diet, told us staff offered them Halal food but they did not give them a choice of meals.
- We received variable feedback from patients about the quality of the food. Some patients said there was a good choice and the food was good. However, most patients we talked with said the food was very repetitive and not very palatable. For example a patient said, "The food could be better; it isn't very good. It is tasteless and repetitive." Another person said they tended to choose curries as they had more taste.

Learning from complaints and concerns

- A total of 79 complaints were received for medical services at the hospital between January 2016 and December 2016. We did not identify any trends or areas of high complaints when we reviewed the data provided by the trust.
- Complaints were discussed at governance half days and ward meetings.
- We saw displays on the medical wards close to the entrances entitled, "Your views matter." These provided information on complaints, concerns and compliments and referred to the patient advice and liaison service (PALS).
- We also saw complaints leaflets in the information racks on the wards.
- Staff were familiar with the process for dealing with a complaint and said they received feedback on complaints at ward meetings and handovers.
- Staff were able to identify changes which were put into place in response to complaints such as facilities for the storage of patients' property

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The clinical governance framework needed further development in some specialties to ensure effective scrutiny of issues and ensure learning was achieved. There was limited involvement of staff below manager level in clinical governance meetings
- The risk register provided by the trust contained no risks for medical services other than oncology and ward staffing levels. A risk staff thought was on the risk register was not included. We had concerns about the escalation of risks and the timeliness of response.
- There was variability in the quality of clinical leadership and management at ward level.
- Although we saw some excellent clinical leadership amongst some medical consultants, we also found a lack of engagement and leadership amongst others. The level of challenge and oversight of senior medical staff and locums was limited.
- There was little evidence of the involvement and engagement of patients and the public in the development of services.

However:

- Managers were aware of the issues within medical services relating to variations in the consistency of the quality of service provision. A number of projects were underway to address these but at the time of the inspection it was too early to demonstrate a significant impact.
- Staff within medical services had won a number of awards from external organisations for good practice in their specialty.
- The re-configuration of services was being planned in preparation for the move to the new hospital.

Medical care (including older people's care)

Leadership of service

- Medical services at the hospital were managed within the medicine and emergency care, care group. Within the care group were three directorates. Acute medicine sat within the emergency care directorate, and other services were clustered under the admitted care and scheduled care directorates.
- Each directorate was led by a clinical director, general manager and therapist or deputy general manager.
- Senior managers were aware of the issues within medical services relating to variations in the consistency of the quality of service provision. A number of projects were in place to drive quality improvement and some progress had been made since the last inspection, however significant challenges remained.
- The matron workforce within medical services was reviewed approximately three months prior to the inspection and the number of matrons was decreased. A view was put forward by staff, that given the challenges within the medical wards, it was difficult for matrons to maintain a visible presence on the wards and provide the level of support required, in addition to attending capacity meetings, driving forward quality improvements, and being involved in strategy.
- We talked with a matron, who had a good grasp of the issues within their area, was motivated to bring about improvements in the quality of care and showed a passion for their role. However, they were concerned about their visibility in areas where there were fewer problems and the ability to work strategically, when some wards required additional support to overcome quality and safety concerns.
- Ward sisters and other staff we talked with told us they felt supported by their matron and said the matron was open, listened to their concerns, and responded positively.
- A management development programme was in progress for wards sisters to enable them to strengthen their management skills. The senior ward sisters said they were managing staff sickness absence more effectively since covering this on the programme. Sickness absence levels were high, although we noted they were reducing.
- We found variability in the visibility of senior ward sisters on the floor and their clinical input. We observed this particularly at our unannounced inspection. It was also apparent when we talked with patients, some of whom did not know who the senior ward sister was, and others who said they saw them regularly.
- Staff on most wards felt supported by their senior ward sisters. They said issues were openly discussed and the senior sisters were helpful and available. However, we also found staff and patients had some concerns on one ward. When we talked with the matron they told us they were aware of the issues and meeting with the person to discuss the way forward with them.
- We saw some examples of good clinical leadership amongst consultant medical staff. For example, an experienced AMU consultant we talked with, was engaged, enthusiastic and had a clear sense of direction.
- Although a consultant told us "vigorous job planning" had helped to bring about changes in practice, consultants felt further challenges existed in relation to job planning and resources to achieve implementation of best practice.
- However, another experienced consultant did not appear to be aware of basic quality standards and told us new patients should be seen within 24 hours rather than the 12 hours standard. In addition, they said they did not see the need for daily ward rounds.
- There appeared to be a lack of challenge and oversight of some medical staff, in that the opinions voiced to us identified above were unchallenged, some consultants did not attend board rounds, a lack of a locum registrar for three days was not addressed and a lack of consultant cover for annual leave left a ward without a consultant ward round for a week.
- A concern was expressed to us about the nursing "voice" not being heard, within the current management structure, and messages being lost in middle management.

Vision and strategy for this service

- Senior managers told us their vision was to provide a world class service to the local population. They said the opportunity provided by the move to the new hospital, was enabling them to review the provision of medical services across the trust. They could review best practice and how it could be achieved in the new service. They recognised the need to harmonise practice across the two hospital sites.

- Staff within cardiology, where the service had already been re-configured, were clear about the plans going forward. Other specialties were less certain about the future and staff in the oncology day unit in particular, were concerned about the uncertainty regarding the future provision of the service.
- The trust values were displayed in a variety of areas within the trust, however, staff had some difficulty in articulating these.

Governance, risk management and quality measurement

- The clinical care group which included medical services held monthly board governance meetings and below this were directorate level meetings. Ward level governance meetings were described by the management team as being "embryonic."
- We reviewed the notes of the care group meetings, which contained evidence of discussion of the expected range of clinical governance topics and review of the notes from each of the directorate level meetings.
- The trust produced an integrated performance report for medical services that was discussed at trust board. This included measurement of performance against national and local targets and ward level information related to key performance indicators.
- The risk register for the medicine and emergency care group provided by the trust contained four risks for medical services. These related to safe ward staffing levels, and three risks related to oncology services. No other risks were identified. From the data provided in the risk register we were not able to determine the length of time risks had remained on the register.
- Oncology risks included excess waits for oncology clinics, differences in wait times for chemotherapy between sites due to staff vacancies and non-compliance with peer review standards for oncology, including lack on oncologist attendance at MDT meetings. When we asked the senior leadership team about actions and progression of these issues, they were not conversant with the detail.
- Staff said lack of availability of patient records in the oncology day unit was an issue and was on the risk register but when we checked the risk register this was not included.
- We had concerns about how issues and incidents were escalated and the timeliness of action to address them. At the unannounced inspection we identified issues relating to the content and accessibility of the emergency resuscitation trolleys on the medical wards. When we returned at the announced inspection four weeks later we found the same issues.
- A consultant said they had completed two incident forms related to the accuracy of CT scan results, which we would have expected to have been escalated. However, we were unable to obtain further information from the trust about these incidents. We were therefore unable to determine whether the incidents were investigated and whether any action was taken.
- Quality improvement half days were held for the care group. Junior medical staff found these useful and said managers were receptive to suggestions put forward by staff.
- Staff on some of the medical wards spoke about "Story Boards" that were prepared by the matron and which contained key messages on how they were doing in relation to key performance issues and priorities for going forward.
- An initiative to improve the consistency of clinical care was in progress. This was part of the safety plan and known as 'always events' which identified 10 key investigations/interventions which should be reviewed for each patient and staff recorded performance against this on a daily basis.

Culture within the service

- Junior doctors were positive about the level of support and the "camaraderie" at the hospital. One doctor said, "There is genuine care for the patients." They said it was a good learning environment.
- Within ward teams, nurses told us staff supported one another and worked well together. A nurse said, "When I first came, I saw how staff supported one another, when they know you are struggling they will help; you get full support."
- A nurse on a ward told us, "The culture is more positive now." "Morale was low at the end of last year but there have been changes at senior level and things are improving."
- However, on another ward, staff felt less valued and involved. A member of staff said, "We used to get together and brought our ideas and talked about things, but now we are not involved in decision making."
- A member of the housekeeping staff described poor communication and low morale. They said they were

moved wards without warning or discussion when they had been on the same ward for a number of years. They said there were rarely any meetings with managers and little communication.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents'andprovide reasonable support to that person."
- The principles of duty of candour were in a trust policy titled "Being Open Policy," which was available for staff to access on the trust's intranet.
- Staff told us they were open and honest when things went wrong and they apologised to the patient and their relatives where appropriate.
- Staff we spoke with were unaware of any written duty of candour information to provide in these situations or of the need for a written letter of apology. We asked the trust to provide examples of letters sent to patients and/or their relatives in medical services in relation to duty of candour, including an apology. They provided one letter with an apology and two others which were the result of concerns raised by patients or relatives and which stated that an external review was carried out and the patient received the correct care. These were the only incidents which the trust said met the requirements for a letter of apology.

Public engagement

- There was little evidence of the involvement of patients and the public in decisions about the development of services. However, managers talked about the way they had engaged with the public to provide reassurance when cardiology services were re-configured. They told us they had responded to concerns about the loss of cardiology services at the Sandwell site by ensuring outpatients and diagnostic services were provided there.
- We were told the trust was using the Expert Patient Programme to enable patients to better manage their long term conditions and prevent unnecessary admission to hospital.
- Gastroenterology were considering the development of patient panels to promote involvement of patients in the service

Staff engagement

- Results from the staff survey indicated an improving level of engagement of staff and we found a mixed picture when we talked with staff.
- Ward managers did not always feel involved with decision making about the future provision of services and changes which would affect their wards when services were transferred to the new hospital. One person said, "We need more clarity about the new wards, their functionality, and specialisms."
- Staff were positive about the "Listening into Action" events held within the trust and said they had the opportunity to discuss issues impacting on the service. However, some staff felt there was little two way communication between staff on the floor and the senior managers.
- We found variations amongst consultants in the level of engagement in change processes to improve the efficiency and effectiveness of the service. Although some consultants were fully engaged and forward thinking, some showed a level of disinterest and were not engaged in improvement initiatives. One consultant said they, "Didn't bother to engage with the changes since others were more interested." There was a lack of recognition of the importance of board rounds and ward rounds in improving care for patients.
- Uncertainty about the future provision of oncology services on the site had created staffing issues as staff had left the service, leaving gaps in staffing and low staff morale amongst the remaining staff on the oncology day unit.

Innovation, improvement and sustainability

- Medical services were moving forward in re-configuring services in preparation for the move to the new hospital. However, some staff felt decisions were "put on hold" in anticipation of the new hospital.
- The ambulatory medical assessment area was developed to improve patient access and reduce the need for admission to hospital.
- Staff within medical services had won a number of awards for their work. For example, the rheumatology team were finalists for Managing Long Term Conditions, Value in Healthcare Awards, for the Health Services Journal and a consultant and specialist nurse won a Healthcare Champions award from the National Rheumatoid Arthritis Society.

Medical care (including older people's care)

- A consultant was awarded Diabetes Healthcare Professional, Quality in Care Diabetes 2016 National Awards.
- The atrial fibrillation team won a clinical research impact award from the Clinical Research Network West Midlands group.
- The respiratory service were selected to take part in the Future Hospitals Project, (RCP) aiming to deliver an integrated care and 'whole system' approach to respiratory care in Sandwell and West Birmingham.

Surgery

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

Information about the service

There are two surgery services operating from City Hospital, One from the main hospital site and a second from Birmingham Midland Eye Centre (BMEC). We have reported on them separately under each domain.

This report contains information relating to surgery services at City Hospital and the Birmingham and Midland Eye Centre.

City Hospital is part of the Sandwell and West Birmingham Hospitals NHS Trust.

Surgical services are provided at all the trusts sites. City hospital provides adult inpatient and day surgery services for specialisms including ear, nose and throat, ophthalmology, breast surgery and urology.

From 01 August 2016 to 31 January 2017, there were 647 emergency cases, 889 elective admissions and 3850 day cases. During 2016, 24861 operations were performed.

We inspected the planned admission ward, main theatres, day surgery theatres and the recovery area. We also inspected the male and female designated wards and the day surgery unit.

We spoke with 32 staff, 16 patients and their relatives and carers. We observed patient care and reviewed 21 medical records.

Changes in the surgical service had involved reorganisation of specialist services between Sandwell General and City Hospital site. The approval of the new hospital had brought about some anxiety to staff groups relating to their future working arrangements and uncertainty about how the new site will affect City Hospital.

Since the previous inspection we were told of and evidenced many improvements including handover procedures, infection control compliance, cleaning schedules, medication storage and patient record security. Ward staff contact with senior staff had improved and the mortality and morbidity meetings were included in the governance meetings.

Birmingham Midlands Eye Centre (BMEC) Surgery:

BMEC is located in a standalone building within the City Hospital site. Eye surgery is also undertaken at Sandwell Hospital by BMEC clinical and medical staff.

Within the BMEC site there were three theatres and an additional theatre dedicated to cataract surgery. There was one theatre available at Sandwell Hospital for ophthalmology surgery. BMEC undertook elective surgery on week days, within both morning and afternoon time slots. Emergency surgery was undertaken on week day evenings and between 8am and 8pm on Saturday and Sunday. Sandwell hospital held seven surgical sessions a week for ophthalmology patients. These were held Monday and Wednesday afternoon, Thursday and Friday morning and both morning and afternoon on a Tuesday.

A joint day-case and inpatient ward housed surgical patients within BMEC. The ward consists of eight side rooms for inpatients, six of which are prioritised for

emergency cases. A trolley bay area and waiting room facilitated day case patients. After 9pm, BMEC ED patients were sent to the ward area to be seen and treated, as BMEC ED closed at this time.

BMEC surgery department underwent workforce changes at the end of 2016, which included the reduction of two separate wards to one combined day case and inpatient ward as part of a cost saving plan.

We conducted the inspection of surgical services at Birmingham Midland Eye Centre (BMEC) between 28 and 30 March 2017.

During the inspection, we visited the theatre area, the inpatient service and day ward. We observed staff undertaking their duties including during surgical procedures. We spoke with two parents of paediatric patients, seven adult patients, and 13 staff members, including housekeeping and porter staff, nurses, healthcare assistants (HCA), operating department practitioners (ODP) and managerial staff within the unit. We reviewed 21 surgical patient records.

Summary of findings

We rated this service as good because:

- Never Events had been reported however robust measures had been taken to ensure patients safety in the future.
- The trust held 10 quality improvement half days (QIHD) per year during which time staff shared learning and attended relevant training.
- Robust application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist was visually monitored on a daily basis.
- Staff were aware of Duty of Candour and their role when things went wrong; they had an understanding of the Mental Capacity Act 2005.
- Staff were seen adhering to the infection control policy of arms bare below the elbow. The use of hand sanitiser and protective clothing policy was also adhered to.
- Theatres and the wards were clean and tidy; cleaning schedules were dated, signed and displayed.
- Medication refrigerators temperatures were recorded daily and medication cupboards were locked.
- We saw that patients medical records were secure in all areas.
- Staff were aware of how to report safeguarding concerns and what to look for when caring for patients.
- Mandatory training rates were variable but on target to be met.
- A dependency 'acuity tool' was used to assess the staffing numbers required.
- Nursing staff vacancies were filled by bank and agency staff.
- Medical staffing was stable and locum cover was arranged as required.

Surgery

- Venous Thromboembolism(VTE) assessments were completed in line with national guidance and individual risk assessments were completed and audited.
- Pre-operative assessments were completed to ensure patients were safe for surgery.
- Multidisciplinary teams worked well together.
- Staff were seen attending to call bells promptly.
- Patients we spoke with told us they had received good cared from friendly staff. They were satisfied that their pain control had been managed well.
- The average length of stay was below the England average for elective and non-elective surgery
- Submission to the national 'bowel cancer audit' performance was recorded as 100% in 2016.
- The trust's referral to treatment time (RTT) for admitted pathways for surgery, was slightly above the England average, for overall performance since January 2016.
- Local senior leadership was supportive and visible.
- Patients and local people were encouraged to get involved in the hospital.

However:

- Safety thermometer information was recorded but not displayed on the wards.
- Staff did not hear about other wards complaints so wider learning was not shared.
- Staff felt listened to when they raised issues, but were less positive about the follow up action. taken. Staff felt they were not being included in plans for surgical services.

Are surgery services safe?

Good

City Hospital and Birmingham Midlands Eye Centre (BMEC) Surgery:

We rated safe as good because:

- Staff were aware of how to report incidents and were aware of learning following these.
- Infection prevention and control was good; staff worked in ways which minimised the risk of infections.
- Adherence to the World Health Organisation (WHO) five steps to safer surgery checklist was to a good standard ensuring patient safety during surgical procedures.
- Staff were aware of Duty of Candour and the Mental Capacity Act 2005
- Staff arms were seen bare below the elbow and the use of hand sanitiser and protective clothing policy was adhered to.
- Theatres and the wards were clean and tidy; cleaning schedules were dated, signed and displayed
- Medication refrigerators temperatures were recorded and medication cupboards were locked
- Patients medical records were secure in all areas
- Staff were aware of how to report safeguarding concerns and what to look for when caring for patients
- Mandatory training and appraisal rates were variable but on target to be met
- A dependency 'acuity tool' was used to assess the staffing numbers required
- Nursing staff vacancies were filled by bank and agency staff
- Medical staffing was stable and locum cover was arranged as required

However:

- Two Never Events had been reported at City Hospital from June 2016 to January 2017.
- Safety thermometer information was recorded but not displayed on the wards. Senior staff were aware of how to view their ward's performance in relation to safety.

- Knowledge of the duty of candour was variable at BMEC. Some staff had a good awareness of the need to be open and transparent with patients following a notifiable safety incident. Other staff were not familiar with this and were unable to describe it.
- Staff at BMEC for completion of mandatory training, including safeguarding training, required improvement.
- At the time of inspection, BMEC staff were not using any form of national early warning score (NEWS) to identify deteriorating patients. However, the trust had recognised this was a safety concern and were taking steps to remedy this.
-
- Incidents Two Never Events had been reported at City Hospital from June 2016 to January 2017. One in maternity services and one in gynaecology services, both involved retained packs. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Robust measures had since been taken to ensure patients safety in the future, which must be maintained, including visual peer review of consultants working practices and unannounced observation of the WHO checklist performance by senior managers.
- Re-audit and observation of the WHO checklist was now a weekly event by senior managers including consultant peer review.
- Wider learning included improved communication; verbal post-operative handover now took place with ward staff.
- When internal packs were insitu it was agreed at 'sign-out' the number of packs and a luminous wrist band was attached to the patients arm for each pack left in situ. When these packs were removed a process was in place to document, with two people present, the removal and the removal of the band. We saw that the safer surgery policy had been updated to include these actions.
- Shared learning between staff took place during the QIHD sessions.
- In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SI's) between February 2016 and January 2017. One incident involved a patient fall and one related to an acquired pressure ulcer.
- Between February 2016 and January 2017, 897 no harm/ low harm incidents were reported at City Hospital under the heading surgery which included all surgery and anaesthetics.
- All staff had access to the electronic incident reporting system. To promote patient safety, reporting of incidents was encouraged. We were told that feedback was given to the reporter when requested. Staff told us they were not made aware of incidents that occurred in other areas of the hospital or other sites; the opportunity of shared learning was not taken.
- We were told that Mortality and Morbidity (M&M) reviews were discussed at quarterly meetings. Senior staff, involved in the case for discussion, was encouraged to attend. We reviewed M&M case presentations and their findings and found them to be robust detailed.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- From January to December 2016, a total of 347 incidents were recorded within surgery at Birmingham Midland Eye Centre (BMEC). Of these, 48 were categorised as 'near miss', 225 as 'none' (no harm occurred), 62 recorded as 'low' (minimal patient harm), and 12 as 'moderate' (short-term harm). There were no incidents recorded as 'severe' (long term harm/ permanent harm) or 'death' for this time frame. The most commonly reported incident related to assessment.
- Staff told us about the process of how to report an incident and gave examples of the types of incidents that would require reporting. Staff told us that incident feedback was received via email to the individual who had submitted the incident; where appropriate other staff members/ areas of work would also be informed. For example, if an incident was raised following a booking error, the booking team would be included in any feedback. Staff reported that feedback following on from incidents they had not directly reported was minimal. However, staff described general learning and information sharing they shared through communications such as the quality improvement half day meetings (QIHD), team meetings, handovers, emails and bulletins.

- Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- From April 2015 to February 2017, one never event was reported for BMEC within surgery. The incident occurred in November 2016 and was described as an incident where patient identity was not established correctly; as a result, the wrong patient was given an eye injection. We saw the findings of the investigation, and the actions taken to ensure this did not happen again. Furthermore, we saw evidence that 'near miss' incidents of a similar nature were discussed at clinical governance meetings in order to enhance staff knowledge and training.
- We spoke to staff about their awareness of the never event and subsequent learning. Some staff showed a good awareness of the event, and could demonstrate steps taken following this time to ensure patient identification was always correct, such as appropriately using the biometric system. Other staff said they were not aware of the event until hearing about it on the local news.
- The trust held regular mortality and morbidity meetings to discuss patient cases. We saw case presentations that were informative and detailed.

Duty of Candour

- Staff we spoke with were aware of 'duty of candour' (DoC) and the need to be open and honest with patients, when things go wrong. Between September 2016 and February 2017 there were eight incidences whereby DoC was applied appropriately within surgery at City Hospital. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- The trust reported that DoC had been followed after the never event described above. We saw a copy of the summary of the investigation which confirmed duty of candour procedures had been followed.
- Staff understanding of duty of candour was variable. Some staff had some comprehension regarding the need to be open and honest with patients. Other staff were not familiar with or aware of the term DoC. Staff reported they were unsure if they had received specific training in this area and data from the trust confirmed they did not provide a separate training session.

Safety thermometer

- The NHS Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month and submitted within 10 days of suggested data collection date.
- The NHS Safety Thermometer was in use by the surgical directorate to record the prevalence of patient harms in the ward environment. Monthly audits of the prevalence of avoidable harms such as pressure ulcers, venous thromboembolism (VTE), falls and catheter-related urinary tract infections were performed. This provides immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Data from the patient safety thermometer showed that the trust reported eight new pressure ulcers, four falls with harm and one new catheter urinary tract infection between January 2016 and January 2017.
- We saw that safety information was not displayed on the wards; Staff we spoke with did not demonstrate any knowledge of the safety thermometer data, including the reason for this being collected or their individual ward performance.
- Specific ward data was available and ward managers were aware of their performance. Data such as patient safety, patient experience, infection prevention and control, staffing and finance were logged and reviewed for each ward. Ward staff were aware of their safety performance regarding specific safe care. On day unit staff showed us their ward safety crosses notice boards which were used to track monthly occurrence of pressure ulcers and falls.
- For example, average year to date data showed that on ward 21 and female surgery ward, of the 14 safety assessments the score was on average 97%. The trust target was 100%.
- Safety posters seen on the wards identified that 'Safety is our top priority'. The trust safety plan set out clear

promises to all patients on the standards they should expect from the service. Safety checklists should be completed within 24 hours of admission, which included decisions about care, recording of their observations, and level of pain will be assessed.

Cleanliness, infection control and hygiene

- Ward areas and theatres were visibly clean and tidy. Throughout the inspection, we saw domestic staff carrying out their specific cleaning duties. We saw signed cleaning schedules in ward areas, patient bathroom and toilet facilities. Ward assigned domestic staff were aware of their responsibilities and the need to maintain a clean environment.
- There were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) and one Clostridium difficile (C.Diff) infections reported between April 2016 and March 2017. Infection rules were displayed on the wards, which identified four general rules, key MRSA rules and key C.Diff rules.
- Ward and theatre staff were observed to comply with the key trust policies e.g. arms bare below the elbow, hand hygiene, personal protective equipment and isolation of infected patients. Hand hygiene audits were carried out unannounced. Planned admissions unit hand hygiene audits for February was 93% and March 95%.
- We observed six patients that had cannulas inserted, all but one patient cannula had a 'date and time' sticker applied to ensure they were managed in line with the cannulation policy.
- Data for Surveillance of Surgical Infections (SSI) in NHS hospitals in England is collected to monitor infection rates post-surgery. Between 01 August 2016 and 31 January 2017, 4058 elective, emergency and day case operations were performed. We requested the inpatient infections reported and infection on readmission; this information was not available.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We saw that staff complied with hand hygiene and infection prevention and control requirements. Staff washed and gelled hands, had arms bare below the elbow and wore personal protective equipment (PPE) such as aprons and gloves when working directly with patients.
- We saw staff adhered to the National Institute of Clinical Excellence (NICE) guidelines 74. Within theatres, patients and staff wore appropriate clothing for surgery, staff adhered to no jewellery or nail varnish directives and sharps and swabs were disposed as per safe practice. Staff gowns and gloves were disposed of in the appropriate waste bin.
- Data from the trust showed that BMEC theatres and BMEC wards achieved between 95 -100% compliance with hand hygiene audits for the time period January 2016 to January 2017; although it was noted that for the ward areas, 100% compliance had been achieved for 11 out of 12 months. This met and exceeded the trust target of 95%.
- We saw the trust training record dated March 2017, which indicated nursing staff compliance with infection prevention training was 77% and 63% for inpatient areas and theatres respectively.
- Both the theatre and the ward areas were visibly clean and tidy; we heard staff consistently ask everyone who entered or exited the ward area, including visitors, to 'gel' their hands. We observed adequate supplies of hand gel in easy to access points.
- Patients told us they found staff to be clean and hygienic; confirming that staff washed their hands and maintained cleanliness throughout patients 'care.
- Trust data showed 100% compliance with cleanliness of shower chairs and toilet chairs from July 2016 to February 2017 across surgery services.
- We saw in the ward area that patients with infectious conditions were located in individual side rooms; with identifying signs placed outside the room in order to prevent contamination.
- Staff told us that patients were screened for methicillin resistant staphylococcus aureus (MRSA) when undergoing general anaesthetic either on admission or at point of arrival. All emergency surgery patients were also screened. Elective patients who were undergoing local anaesthetic were not screened at all for MRSA. We saw within reported incidents provided by the trust, that staff reported if a patient due for general anaesthetic had not been screened, with the result that the surgery was re-arranged. Data supplied by the trust showed no cases of MRSA from April to December 2016 within surgery across the SWBH trust.
- From April 2015 to December 2016, the trust reported no cases of Clostridium difficile (C.diff) within BMEC surgery.

Environment and equipment

- We saw that wards were clutter free and tidy. Oxygen cylinders were stored securely. Staff told us that equipment was sufficient and well maintained. Electrical equipment was found labelled and dated as appropriately portable appliance tested.
- Resuscitation equipment was checked and found to be in order in all areas we inspected. Resuscitation trolleys were unlocked with a loose cover to protect the equipment. Emergency medication was locked in the ward cupboards.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We saw that resuscitation trolleys had been checked appropriately and contained equipment that was within use by dates. However, the resuscitation trolleys were combined for both adults and paediatrics and the equipment for both was not separated meaning staff may lose time looking for appropriately sized stock. Staff told us that the combining of adult and paediatric trolleys was a wider decision made by the trust resuscitation team.
- Staff told us, and we saw, portable equipment that could be used with patients who may have difficulty undertaking appointments with more traditional ophthalmologic equipment, such as bariatric patients and patients with a learning disability. This equipment could be transported to the main emergency department at City Hospital should a patient present there with multiple medical requirements, including ophthalmology.
- The trust reported that portable appliance testing (PAT) was conducted yearly via the estates department.
- An environmental audit conducted at BMEC in December 2016 found the whole area required a review in terms of cleaning, storage space and general decoration. However, the majority of comments relating to this highlighted areas other than surgery. It was also noted that signage around the department was poor. During our inspection, we saw that initial signage from the main reception to the surgical area was not very clear in terms of directing patients to the stairs or lift area they were required to enter in order to arrive at the correct location.
- We saw a further environment audit completed on the surgical ward area in February 2017. At the time of our inspection in March 2017, approximately 50% of the actions identified as a result had been completed.
- Data provided by the trust showed a yearly structured plan for maintaining equipment that included equipment for BMEC.
- We saw the trust had policies for the management of healthcare waste and sharps and for decontamination of tonometers and rigid lenses used in ophthalmology. The policy for management of healthcare waste and sharps was out of date, having a review date of July 2016. The policy for decontamination of tonometers and rigid lenses used in ophthalmology was in date with a review set for October 2017.

Medicines

- We saw that medicines were stored and administered in a safe way. Electronic lock key recognition had been introduced to ensure relevant staff had access to the medication at all times. This process logged each staff member's actions resulting in an audit trail.
- Refrigerator temperatures had been checked and recorded daily on all wards and theatres.
- We saw nurses checked patients' identification bands prior to the administration of medication, including checks for any allergies. Allergies were clearly documented in the medication record.
- Controlled drugs were stored, checked and administered appropriately in all areas. Nursing staff were aware of the policies for the administration of controlled drugs as per the Nursing and Midwifery Council, standards for medicine management.
- Take home medication, for discharged patients, was arranged during the patient board round, the day prior to their discharge ensuring patients were not delayed leaving the ward and their bed became available at the earliest opportunity. Patients were given clear explanation on the medication prior to discharge.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- A medicines optimisation policy dated January 2016 detailed arrangements for prescribing, requisition, storage, administration and control of medicines in accordance with National Institute of Clinical Excellence (NICE) guidance NG5 Medicines optimisation: the safe and effective use of medicines. This had been shared across the trust intranet to enable staff to have direct access. Staff we spoke with were able to locate the policy and recall its principles.
- All medicines were supplied and administered against an individual prescription by a doctor, and recorded on

a medicines administration record (MAR). All 11 MARs we reviewed in the day surgery unit were fully documented in accordance with local and national guidance, and showed that no prescribed medicines had been missed or omitted. Where applicable, allergies were clearly documented and acted upon.

- In all patient areas we visited we found medicines were stored securely in locked cupboards or, where applicable, in a pharmacy refrigerator. Refrigerator temperatures were monitored and recorded at least daily to ensure medicines were kept in optimal conditions. All the recorded temperatures were within the required range. However, the ambient room temperature of medicines' storage areas in the day surgery unit was not monitored. We escalated this to the senior management team?
- Investment in a new electronic key system had greatly improved the security of medicines across the trust. Only authorised staff had access to medicine cupboards and the electronic system had the ability to track who had accessed medicine cupboards.
- We saw within minutes of a team meeting in March 2017 that managers updated staff upon changes to medication classification and storage requirements.
- Emergency medicines for resuscitation were stored on dedicated trolleys in all of the clinical areas we visited. This meant they were available for immediate use. However, they were not protected with a tamper evident label or seal to provide visible evidence that they were safe to use, as recommended in guidance issued by the UK Resuscitation Council, November 2016.
- We saw medicines to be used in emergency treatment of anaphylactic (serious allergic) reactions were available in pre-filled syringes.
- Arrangements were in place to check patients' medicine requirements from the point of admission. For example, taking a detailed medicine history and undertaking medicine reconciliation on admission to hospital. The pharmacy team checked prescription charts for any missed doses with particular emphasis on omitted antibiotics or any high-risk critical medicines.
- Audits on antibiotic prescribing were undertaken in line with national and local guidelines and discussed at the drugs and therapeutics committee. Specific areas were identified where improvements could be made including raising awareness of correct prescribing with junior doctors.
- A regular medicine stock top up service was provided by pharmacist staff. Staff we spoke with was positive about the service and told us it was very rare to run out of any medicines stock. Measures were in place to arrange for emergency supplies when the pharmacy was closed.
- Controlled drugs (CDs) are medicines which require additional security. CDs were stored in locked cupboards with restricted access which were bolted to the wall. We saw stocks of CDs were checked by two appropriately qualified members of staff at each shift change, and documented in the controlled drugs register. At the time of our inspection all stock levels were correct.
- An accountable officer for CD's had responsibility for ensuring safe storage and recording of CD's. Quarterly audits of CD medicine records and storage were undertaken and the reports shared with the Medicine Safety Committee and the Local Intelligence Network. Any issues identified were highlighted and investigated with subsequent learning from incidents shared across the trust.

Records

- In all areas we inspected we saw patient's medical notes were secure. We saw notes trolleys closed and in close vicinity of the nurses station.
- Nursing care records were stored in the patient bay. These showed evidence that patient risk assessments were completed on admission to the ward. For example, we saw that falls, mobility and nutrition were assessed and monitored.
- Pre-operative assessments took place in the pre-assessment clinic and we saw that the individual information was checked on the day of surgery.
- Some patients were linked to an electronic system known as Vitalpac, which alerted medical staff when their observations were out of their normal range. Staff on the ward showed how the data was collected on a hand held device, which quickly identified signs of patient deterioration and automatically summon timely and appropriate help through electronic alerts.
- Fluid and food charts, in place for four patients were seen completed appropriately.
- The 21 medical records we reviewed during the inspection were well organised with entries signed and dated.
- The trusts clinical effectiveness committee reported in the 2015/2016 records audit that a daily entry was made

in 96% of cases where deemed relevant. Presence or absence of allergies was recorded in 93% of cases on prescription sheets. Patients who were at high risk of VTE and who were eligible to receive thromboprophylaxis were prescribed it (94%). Safer surgery checklist audit showed 99% compliance with the completion of the three sections for those areas currently reporting on their performance. For elective lists, there was 99% compliance, with the brief and debrief requirements.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We reviewed 21 sets of surgical patient records. BMEC used a paper based record system at the time of the inspection. The patient records on site were stored securely; at the admission area for surgery. Patient records were mostly completed to a good standard.
- Out of 21 records looked at, 20 contained a fully completed World Health Organisation (WHO) surgical safety checklist. One checklist was partially completed; the 'sign out' stage had not been filled out.
- We saw, pre-operative and theatre assessments had been consistently completed fully, and nursing observation notes were completed to a high standard. Discharge information was noted within all pre-operative assessments. All but two sets of records had discharge information provided to the patient and the patient's GP.
- The trust were planning to move to a paperless record system as part of their vision. All staff spoken with were aware of these changes and some staff were actively involved with this process of change.
- All patient records for BMEC surgery were previously kept at Sandwell Hospital. Due to the forthcoming changes to a paperless system, these records had been sent to an external company for storage and scanning. Staff reported that since this process had started there had been significant problems with patient records not being present when required resulting in cancelled appointments and operating lists. We asked the trust about arrangements for managing this and they informed us that a piece of service improvement work is taking place around theatres which included contacting patients 72 hours prior to ensure they are ready for surgery and ensuring notes are present.

Safeguarding

- Staff we spoke with was aware of how to report safeguarding concerns and what to look for when caring for patients.
- No safeguarding referrals had been raised within surgery between September 2016 and January 2017.
- The trust annual target for level 2 safeguarding training was 95%. The department had 27 staff who were required to undergo level 2 training. At the time of our inspection 64% had completed the training with the remaining staff on target to be achieved by July 2017.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Staff demonstrated a good understanding of signs and symptoms of abuse and were aware of how to contact the lead safeguarding nurse.
- We saw the trust were implementing an action plan to raise staff awareness of child sexual exploitation (CSE) and to ensure CSE identification will be incorporated into the future online patient record system.
- Staff told us the process they followed to report a safeguarding concern; dependant on staff grade. The trust provided training records that showed that 97% and 100% nursing staff within BMEC theatres and the ward area respectively had completed adult safeguarding level one; and 100% of these staff had completed adult safeguarding level two. 100% of nursing staff had completed children safeguarding level one, and 97% of the inpatient ward nursing staff had completed safeguarding children level two. Only 90% of nursing staff had completed children's safeguarding level two within theatres which was below the trust target of 95%.
- Medical staff within ophthalmology were recorded as being under target for safeguarding target. 77% were trained in adult safeguarding level one and two; with 79% being trained in children's safeguarding level one, and 51% in children's safeguarding level two.
- No surgical ophthalmology staff were recorded as having completed child safeguarding level three training. Within BMEC two orthoptists were recorded as having completed this training. However the trust safeguarding team were up to date with level 3 safeguarding children training.

Mandatory training

- Mandatory training was delivered though specific training days, e-learning and trust wide training days. Staff told us they discussed their training needs during their appraisals. The trust target for training compliance was 95%.
- Mandatory training which included manual handling, fire safety, basic life support, information governance, safeguarding and infection control was completed annually.
- Training records showed a wide variance between wards and departments in completion rate, for example at the time of the inspection, the wards completion rate ranged between 60% and 100%. However, we were told that this was due to departments and wards attending training at various times throughout the year. Planned projections for attendance were on target to achieve 100% compliance by the end of the training year (July 2017).
- Medical staff mandatory training rates also showed a wide variance in the completion rate. Compliance ranged between 43% and 96% with planned projections for attendance being on target to achieve 100% compliant by the end of the training year (July 2017).
- Staff in theatres used appropriate manual handling techniques to transfer patients from the trolley to table.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Data from the trust, dated March 2017, showed that nursing staff within theatres and the surgical ward area had met the trust target of 95% for the majority of mandatory training. For example, 100% of nursing staff had completed equality and diversity training.
- Training areas in which nursing staff had not met the trust target included conflict resolution update; theatre staff had achieved 62% and ward staff 88%. 83% of theatre staff had completed fire safety training; although 100% ward staff had completed this. Infection control training completion figures were low; 77% of ward staff and 63% of theatre staff had completed this. Other areas in which nursing staff were below the trust target included information governance for both ward (78%) and theatre staff (48), and medicines management for theatre staff (83%).
- Resuscitation training; basic life support completion rates were 63% for both ward based and theatre nursing staff resulting in 38 out of 60 staff being trained; significantly below the trust target. We saw a training matrix which indicated out of date staff were scheduled to undertake this training within May and June 2017.
- We spoke to theatre staff who told us that due to recent changes to the workforce and long term sickness; they were understaffed, resulting in arranged training being cancelled so patient theatre lists would not be cancelled. However, we saw that acting theatre managers were arranging and booking staff training in order to ensure all required training was achieved.
- Medical staff across BMEC were consistently below the trust target for all mandatory training ranging from 17% for transfusion training and 81% for basic consent training.

Assessing and responding to patient risk

- We found robust application of the World Health Organisation's (WHO) 'five steps to safer surgery' checklist in the four theatre sessions we observed. All stages were carried out correctly and recorded, as the procedure stipulates. Whilst observing, we saw that the checklist was completed on all occasions including the 'time out' session where staff review the whole team members present and the surgery to take place.
- In theatre, a communication tool had been introduced as a local intranet page accessed by all staff and users. This communication tool promotes consistent, timely information to all staff and users within the theatre department. The nurse and operating department practitioner monitored the team brief, equipment issues, WHO checklist, debrief and any cancellations via the electronic tablet.
- The WHO checklist was audited observationally and retrospectively using patient records. Audits showed medium level of compliance; For example, the May 2016 trust audit score showed that all patients had a checklist in place with 25 out of 30 patients having their checklists 'fully' completed (83%). Since that time the electronic system had been introduced and used to monitor the compliance with a newly introduced trust target of 100%. Data was not yet available.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) state that at all times there should always be at least one member of staff present who is Advanced Life Support (ALS) trained. An anaesthetist should always be available to attend immediately; who will provide further ALS trained 'cover' for emergencies

in the recovery area. However, the anaesthetist does not require being physically present at all times. At the hospital, we found that recovery nurses and operating department staff were trained to ALS level.

- Theatre staff visually and verbally confirmed swab and instrument count between practitioners in line with Association for Perioperative Practice (AFPP) recommendations for safe practice 2016. This, with patient information, was recorded on a white board as per the AFPP best practice guidelines.
- AAGBI discharge criteria was followed, for example, all discharged, day surgery patients received verbal and written instructions and were warned of any symptoms that they may experience. These instructions were given in the presence of the responsible person who was to escort and care for the patient at home.
- The 'sepsis six', had been introduced at the trust to improve outcomes for septic patients. When the six factors are completed within the first hour following recognition of sepsis, the associated mortality has been reported to reduce by as much as 50%. The six factors which were displayed on the ward included oxygen administration, taking blood cultures and blood analysis, giving intravenous antibiotics, starting intravenous fluids and resuscitation and monitoring hourly urine output.
- Magnetic board signs were in place above patient beds to discreetly alert staff when caution is needed for example manual handling or medication allergies.
- National Early Warning Score (NEWS) alerted clinical staff to any vital signs that fell out of safe parameters for the patient's normal scores. This information was then alerted to the senior medical staff to attend to the deteriorating patient. NEWS is a simple, physiological score that may allow improvement in the quality and safety of management provided to surgical ward patients. The primary purpose is to prevent delay in intervention or transfer of critically ill patients.
- Confidential Enquiry into Patient Outcome and Death (CEPOD) classification, describes the need for immediate, urgent, expedited or elective surgery. One CEPOD specific theatre was staffed 24 hours a day, seven days a week for immediate life, limb or organ-saving intervention including the intervention for acute onset or clinical deterioration of potentially life-threatening conditions.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- In theatres we saw that staff completed the World Health Organisation (WHO) surgical safety checklist to a high standard. The WHO surgical safety checklist is a system to safely record and manage each stage of a patients journey from the ward through the anaesthetic and operating
- theatre. We checked 21 sets of records that showed that 20 out of 21 records had a fully completed checklist. One checklist did not have the 'sign out' section completed. We saw standard operating procedures detailing completion requirements of the WHO checklist within ophthalmology theatres for the selection and management of implantable lenses.
- We saw WHO checklist audit results for the time period November 2016 to May 2017. These showed that within the eye cataract unit, and all eye theatres; WHO checklist adherence was 100%. The only exception was emergency surgery eye patients whereby one patient out of 100 checked did not have all three sections of the WHO checklist completed.
- We saw that a concern surrounding the counting of instruments had been raised within a clinical governance meeting in December 2016 whereby the trust policy was not being followed due to the volume of patients being operated on. Specifically, instruments were checked before starting a procedure but only the instruments that could be lost in an eye were counted at the end. We asked the trust to clarify if this was still a concern. In May 2017, the trust confirmed that this count is now completed as per the trust policy.
- Staff told us they completed observations of patients following surgery both within the recovery area of theatres and on the ward. We saw within patient records that nursing staff observations were completed to a good standard.
- We saw data from the trust that showed a list of objectives following a 2015/2016 audit regarding the improvement of managing deteriorating patients. For example, an objective to ensure clinical staff have the knowledge to recognise and respond to a deteriorating patient was set and recorded as 'ongoing' in September 2016.
- Staff told us that they were trained to deal with deteriorating adult patients, and planned paediatric cases. Please see the Children and Young People report for BMEC for information regarding paediatric patients.
- The trust told us they did not conduct formalised national early warning scores (NEWS) for patients in

BMEC surgery. The trust informed us this was a safety concern and was highlighted as part of a safety planning process within April 2017 to address this. We saw this was discussed in a ward team meeting in March 2017, during which staff were informed there was NEWS training available and they were required to complete this.

- We saw that the ward area assessed risks such as falls risk, and used magnetic symbols attached to patients' beds if such a risk was identified. Therefore staff were aware and could manage these patients appropriately.
- Out of hours, staff had access to on call consultants should they require advice. Any non-ophthalmologic medical emergencies were dealt with through City Hospital ED. The trust had a transfer of patients policy which covered both adult and paediatric emergency transfers. However this policy was out of date by four years; it should have been reviewed in May 2013.

Nursing staffing

- Biannual acuity reviews were completed using the Safe Staffing Acuity Tool (Shelford Group) with the last review held in January 2017. City hospital held a daily capacity meeting attended by the ward manager from each ward; staffing issues across the site were discussed to ensure efficient and safe use of skill mix. Daily staffing numbers were displayed on the wards and collated daily on a spreadsheet; this was used for the monthly chief nurse submission to facilitate the safe staffing return. There was sufficient nursing staff to meet the needs of patients during the day and the night.
- Staffing ratios on the surgical wards were met with the reliance of bank and agency nurses. All wards had a supervisory ward manager who was not included in the ward numbers. The skill mix ensured that the senior sister on the ward was supported by band 5 and band 6 staff nurses. The ward manager was supernumerary; however, they supported the staff to meet the patients' needs when required.
- Nursing staff handovers took place at the start of each shift with office and bedside discussions taking place in the patient bays.
- Absence of staff was covered by block booked, regular bank or agency staff where possible. Bank and agency staff usage was reported as high due to staff vacancies, levels of staff sickness and on occasions due to issues staff not being flexible with rostering. During 2016, bank and agency staff usage ranged between 0.4% and 23%.
- The trust target for nurse sickness rate was 2.5%. The nursing sickness rate for the period 1 January 2016 to 31 December 2016 was 3.2%,

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Nursing staff within surgery at BMEC had recently experienced workforce changes in September 2016. Staff and management within the ward area reported that although the changes were unsettling at the time; they had adjusted and were now appropriately staffed with no agency usage in this area. As of the 1 February 2017, data from the trust showed that the ward area was fully staffed. Theatre staff told us that the workforce changes had had a significant impact upon this area; resulting in less clinical staff in post than required.
- We saw that nursing staff sickness rates on the inpatient ward area at BMEC was 3.1% on average between January to December 2016. This was higher than the trust target for staff sickness, which was 2.5%.
- We saw during the inspection that there were sufficient nursing and other clinical staff on duty to ensure patients received safe care and treatment. Within the ward area, planned versus actual staffing levels matched and met the requirements for safe staffing. However, within theatres we were told by staff and management, that theatre lists were cancelled regularly due to unsafe staffing numbers to proceed. The concerns around theatre staffing were discussed within a clinical governance meeting in December 2016, and added to the surgery risk register. Management told us recruitment was ongoing; with two band 5 nurses having been recently recruited, and one vacancy being recruited for.

Surgical staffing

- Medical staff attended the ward seven days a week and daily consultant ward rounds took place. Twelve general consultants, two long-term locum consultants and one short-term locum consultant supported surgical services. Two consultants provided cover for all emergency patients, emergency theatres and as required cover for City. One consultant was available for cross-site cover between 08.00 and 18.00hrs.
- The trust employed fewer consultants (37%) than the England average (44%) and more middle grade doctors (14%) than the England average (10%). There were currently more junior doctors in post (14%) than the England average (10%).

- Medical staff sickness rate between January 2016 and December 2016 was recorded as 0%.
- Medical staff handovers took place at the beginning of each shift and following 'on call' shifts.
- Staffing levels were displayed in theatre showing that the department was staffed in line with AFPP recommendations for safe staffing.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Ophthalmic surgery was consultant led and delivered.
- Data from the trust showed that there was adequate planned medical cover for the inpatient ward. Medical staff were on site between 9am to 5 pm; following which on call medical cover was in place. A consultant was on-call at all times including out of hours and at weekends and bank holidays.
- Ward cover was provided by on site two medical staff throughout the core week day; 9am to 5pm.
- For weekends and bank Holidays, BMEC had a consultant on call to cover the full 48 hour period, a senior trainee doctor on call for 24 hours and a trainee doctor on call from 9am to 8.30pm. Additional on call cover was provided by two trainee doctors; this covered the full weekend. In addition, BMEC had a regional vitreoretinal on call service that manages vitreoretinal emergencies. This service was provided by the consultant vitreoretinal surgeon and vitreoretinal Fellows.

Major incident awareness and training

- Major incident policy and plans were in place, which described staffs responsibility regarding their actions should an incident occur. Emergency procedures were generally carried out on the Sandwell site. City Hospital had facilities, which could support patient safety in an emergency incident.
- Staff we spoke with were aware of the major incident policy but could not recall any specific training or scenario training.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Staff demonstrated an awareness of how to respond in the event of a fire and reported they had annual updates and fire safety training.
- The trust had an in date major incident plan for all staff to access.
- BMEC held theatre lists specifically for unscheduled emergency admissions between 5 and 9pm. If required patients could be operated upon during the scheduled elective theatre lists. Six of the eight side rooms within the inpatient ward were allocated to emergency admissions.

Are surgery services effective?

Good

We rated effective as good because:

- Patient outcomes from the 2016 National bowel cancer audit were within expected levels
- Patient risk assessments were completed in line with national guidance
- Patients were satisfied that their pain control had been well managed
- Meals were served during protected visiting times
- There was robust multidisciplinary team working throughout surgery
- Staff had a good understanding of the Mental Capacity Act 2005
- BMEC demonstrated positive outcomes for patients undertaking surgery.
- BMEC Staff were provided with a robust induction programme and undertook training to ensure they were competent within their roles.
- BMEC Staff received yearly appraisals and reported that these identified areas for continued professional development.

However:

- Engagement with the National Emergency Laparotomy Audit was poor and outcomes were mixed.
- There was no formal competency framework for nursing staff working in surgical specialisms after their initial competency 'sign off' stage.
- Not all patients had been previously consented for surgery on arrival in the planned admission ward
- BMEC Staff were not assessing the need for, or applying deprivation of liberty safeguards, when these may have been required.

Evidence-based care and treatment

- Care pathways were in place to ensure that best practice was followed, for example, management of sepsis.

- Patient's individual assessments were recorded on admission including Malnutrition Universal Screening Tool (MUST) and falls risk assessment.
- Venous thromboembolism (VTE) assessments were recorded preoperatively, in line with national guidance.
- We saw minutes of February's 'centre operational governance meetings' where new or updates to national and local guidelines were discussed.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We saw that patient treatment was in line with appropriate national standards such as National Institute of Clinical Excellence (NICE) guidelines, the Royal College of Ophthalmologists (RCOphth) and the Royal College of Nursing (RCN). We saw lists of local guidelines, policies and procedures were monitored within clinical governance meetings to ensure these were updated within set timescales.
- The trust had undertaken an audit of retinal detachment rates between September and December 2016 to demonstrate they were meeting national standards. This audit identified that UK British and Eire Association of Vitreoretinal Surgeons (UK BEAVRS) guidelines and standards were being met, such as 'acute 'macula on' Retinal Detachment will undergo surgery within 24 hours of diagnosis'. For this standard, the trust achieved 96.5% compliance, which equated to 55 out of 57 patients.
- We saw an audit had been conducted on the process of 'stop before you block' within theatres, to ensure adherence to national guidelines around safer surgery. An email summarising the audit results sent in March 2017 confirmed 100% compliance with this process.
- We saw a clear action plan following a peer review conducted within BMEC surgery to ensure staff were following trust policies and national guidance. This detailed where good practice could be enhanced; setting clear objectives and timescales to achieve each action.
- An audit of time taken to arrive from a waiting area to theatre was completed weekly. We saw the audit results for December 2016 to May 2017 which showed time ranged from three and a half minutes for the cataract theatre to 32 minutes for theatre two. The average time for all four theatres within BMEC was 14.1 minutes.

Pain relief

- Patients were satisfied that their pain control had been well managed. Pain relief audit collected as part of the safety thermometer showed that 100% of patients were satisfied with their pain relief between July 2016 and March 2017.
- We were told that patient's post-operative, pain relief options were discussed at the pre op assessment. Patients confirmed that they had been asked about their preferred pain control.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We were told by staff, and patients, that ophthalmologic patients tend to experience minimal pain related to their treatments. However, we saw that pain levels were checked and monitored post procedure to ensure patient comfort.
- Patients told us staff asked about their levels of pain and discomfort throughout their stay. We also saw scale based pain scores recorded within patient records.
- Pain relieving medication such as paracetamol was stored securely on the ward for timely administration if required.

Nutrition and hydration

- Healthcare assistants conducted comfort rounds and provided patients with food and drinks. A drinks trolley was available for patients to provide themselves with drinks throughout the day.
- Food and fluid balance charts were completed for those patients that required observation due to their condition. Between October 2016 and February 2017 the trusts nutrition audits showed that fluid balance completion ranged from 87% (November 2016) to 98% (February 2017) and food diary completion ranged from 87% (November 2016) to 98% (January 2017).
- Meals were served during protected meal times with restricted visiting and we were told that staff or their preferred carer supported those patients who required assistance. The protected mealtime audit scored 100% in surgery between October 2016 and February 2017.
- Intravenous fluids were prescribed and administered, when diet and fluids were restricted. Referral to a trust dietician was arranged when concerns relating to a medical condition, malnutrition or dietary intake were identified.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Within patient records we saw that advice was given to patients regarding eating and drinking pre procedure depending on the type of anaesthetic they were due to receive.
- We saw that staff offered hot and cold drinks regularly within the ward area. Patients could also order meals from a menu, which offered a range of different foods, including specific dietary requirements.
- We saw that patient fluid levels were monitored, and where necessary patients were encouraged to intake more liquid to aid hydration.

Patient outcomes

- In the Patient Reporting Outcomes Measures (PROMS) from April 2015 to March 2016, performance on groin hernias and varicose veins was worse than the England average, with fewer patients reporting an improvement, and more reporting a worsening compared to England as a whole.
- Patient outcomes from the 2016 National bowel cancer audit were within expected levels. The risk-adjusted 90-day postoperative mortality rate was 6.7% compared to national performance of 3.8%. Risk-adjusted 2-year postoperative mortality rate was 21.1% compared to national performance of 20.9%. Risk-adjusted 30-day unplanned readmission rate was 12.4% compared to 10.1% nationally.
- November 2016, 62-day GP referral to treatment target was met with achievement at 85.3%.
- The 'two week wait' target in November 2016 was achieved in 93.5% of cases, which maintained the pattern of previous months.
- A rostered consultant was available 24 hours a day for emergency surgery cases.
- Patient outcomes in the 2016 National Emergency Laparotomy Audit (NELA) were mixed. 21% of the eligible cases were submitted to the audit. This was worse than the national performance of 70% and below the national audit standard of 80% and means that engagement with the audit is poor. In terms of outcomes the hospital was better than expected with a green (>70%) rating for the crude proportion of cases with pre-operative documentation of risk of death based on 15 cases. City Hospital was similar to expected with a green (>80%) rating for the crude proportion of cases with access to theatres within clinically appropriate periods; based on 12 cases. They were worse than expected with an amber (50-79%) rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre based on 14 cases. They achieved an amber (50-79%) rating, not meeting the national audit standard of 80% for the crude proportion of highest-risk cases admitted to critical care post-operatively; based on 11 cases. The risk-adjusted 30-day mortality for City Hospital was within expectations; based on 35 cases.
- The risk-adjusted 30-day mortality for City Hospital was within expectations; based on 15 cases.
- Results of the national emergency laparotomy audit 2015/2016 showed that 80% of patients arrived in theatre in timescale appropriate to urgency, which was above the national standard. Consultant surgeon and consultant anaesthetists were present in theatre between 80 – 100%.
- We saw data that evidenced 100% of patients within surgery had their MUST assessment completed within 12 hours of admission.
- Between October 2015 and September 2016, patients admitted for non-elective admissions including the top three specialties based on count of activity. Ophthalmology, urology and ENT had a higher than expected risk of readmission compared to the England average and a higher expected risk for elective admissions including the top three specialties urology, general surgery and ENT based on count of activity.
- Between October and December 2016, theatre utilization was on average 71%.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- The trust monitored outcomes for cataract treatment. From February 2016 to March 2017, the trust undertook 3777 operations, out of 4569 cataract procedures. Of 2787 'eligible eyes' (patient's which could be included within the monitoring process) which 75% of patients reported improved post-operative visual acuity.12% patients reported no change and 12% reported a worsening in their post-operative visual acuity.

- The trust also recorded operative complications, anaesthetic complications and post-operative complications. 95% of operations had no complications, 62% had no anaesthetic complications and 82% of cases had zero post-operative complications.
- The trust provided data relating to glaucoma operations reported that 1309 operations had been performed from February 2016 to January 2017, with a success rate of 80%.
- Staff told us they had recently received feedback regarding posterior capsule rupture (PCR) rates; BMEC rates were 1.47% against a national standard of 1.97% therefore performing better than the national average.
- We saw that as part of the retinal detachment audit, referenced above within 'evidenced based care and treatment', patient outcomes were monitored. This audit showed that between September to November 2016, 80.9% of patients undergoing retinal detachment surgery had primary success. This fell within the normal limits of success rate for this type of surgery.
- We saw that management from BMEC attended clinical governance board meetings within the surgery directorate. We saw minutes from these meetings spanning December 2016 to January 2017 showing that audit activity was planned and reviewed within these meetings.

Competent staff

- The trust held 10 quality improvement half days (QIHD) per year during which time elective surgery was not scheduled to enable maximum staff attendance. In addition to delivering trust messages at these events, staff also undertook directorate and area specific training to develop skills and knowledge. Minutes of the sessions were kept, in addition to any training updates; therefore, staff unable to attend could view the material on the intranet.
- Agency staff completed a competency checklist with the nurse in charge of the ward they were working. Agency staff received a full theatre department induction prior to working a shift.
- Identified scrub practitioners were trained Surgical First Assistants (SFAs) and staff confirmed that those appropriately qualified would act in this role. Scrub practitioners performed dual role duties only for minor procedures in line with Perioperative Care Collaboration 2012 recommendations.
- Staff received annual appraisals by the ward manager where their individual performance and professional development was discussed. April 2016 to February 2017 records showed that 100% of nursing staff on planned admission unit, 87% of theatre nursing staff and over 83% of nursing staff on the surgical wards had received an appraisal. On male urology ward we reviewed eight members of staff records, but found no evidence of recent appraisal. We were told that one appraisal was due to long-term sickness or absence. Current appraisal rates were on target to be achieved in line with the trusts target of 100%.
- Nursing staff told us they undertook competency programmes for skills such as medicines management and venous cannulation. No structured competency framework was in place for nursing staff working in specialisms such as urology, and gastroenterology. Post operatively these patients may present with a higher level of dependency and increased skills to care for their needs may be necessary.
- Consultants we spoke with individually and as part of focus groups told us that they received appraisals, which was required as part of their professional revalidation.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Data from the trust reported the appraisal rate for nursing staff within BMEC surgery was 100% for the time period April 2016 to February 2017. For all medical staff within BMEC, this was recorded at 93%; therefore 79 out of 85 staff had received an appraisal. All staff we spoke with told us they had received an appraisal within the last 12 months and found this a useful process for identifying future professional development. However, staff within theatres told us gaining time to attend training related to professional development, such as management could get cancelled due to the low staffing levels.
- Nursing staff within the ophthalmic department had access to a nurse educator who attended weekly to update staff competencies. Staff were given workbooks to complete which incorporated key areas of ophthalmic knowledge. We saw a nurse personnel record which included an up to date competency log highlighting both mandatory and additional job specific training, with dates of completion recorded. Nurses also had access to online training through the University of Manchester.

- We were told that approximately four members of staff from the ward were awaiting to undertake this university training; the remainder had already completed this.
- We were told and we saw there was a clinical induction programme for managing new nursing and operating department practitioner staff. Staff completed a three month induction programme which covered mandatory and role specific training, time to shadow and a period of supernumerary working. New staff were allocated a mentor to support their induction. This was a flexible process, therefore if a new member of staff demonstrated full competency prior to the end of the three months, they could be added to the full staff rota early. Alternatively, we were told of the process that was followed should a new staff member not meet the required level of competency at the end of the three month process. This involved setting action plans for the staff member and identifying appropriate support for that individual.
- Nursing staff told us they were able to complete revalidation when required, and were allocated a member of staff to support them with this. The nurse educator also delivered a training session on the process during one of the centre's quality improvement half days (QIHD) and we were shown their 'revalidation folder'. The folder contained guidance on how to go through the revalidation process, the trust's standard operating procedure for revalidation, evidence gathering, acting as a confirmer and a checklist of requirements and examples of appropriate supporting evidence. The nurse educator showed us their electronic records of all nurses' revalidation dates. They told us they emailed every nurse six months before their revalidation due date with a checklist to complete for the process, and arranged a meeting with them to pre-assess their portfolio and supporting evidence.
- The trust held 10 quality improvement half days (QIHD) per year during which time elective surgery was not scheduled to enable maximum staff attendance. In addition to delivering trust messages at these events, staff also undertook directorate and area specific training to develop skills and knowledge. Minutes of the sessions were kept, in addition to any training updates, therefore staff unable to attend could view the material on the intranet. We saw minutes from two QIHDs which confirmed training had taken place within previous meetings. We also saw staff were informed of updates to good practice and necessary training to be completed such as diabetic training.

Multidisciplinary working

- There was evidence of robust multidisciplinary team working throughout surgery with a shared understanding of each other's role and responsibilities.
- Physiotherapists and occupational therapists attended the wards daily and contributed to the daily board round patient review. Dieticians, speech and language therapists and social workers all attended patient reviews as necessary.
- Staff were aware to follow the escalation policy for patient with sepsis who required immediate review. Patients received prompt screening when escalated for sepsis by a multi-professional team.
- During pre-admission process staff discussed the arrangements for discharge were considered prior to elective surgery taking place. If necessary contact was made with families or carers when discussing discharge plans.
- Key information about older people with complex needs was communicated verbally to members of the community health team on discharge including tissue viability (pressure risk) and nutritional assessment and risk.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Staff told us they worked alongside other health care practitioners such as a diabetes specialist and occupational therapists, who came to carry out functional assessments for patients to manage with changed vision.
- Learning disability (LD) specialists were available to aid the care and treatments of patients with a learning disability. An example was provided of an incident where an LD specialist, paediatric staff and anaesthetist worked effectively to enable a patient to undergo surgery in a calm and effective way.
- BMEC liaised with social care providers when required in order to ensure patients who needed a care package on discharge received this.
- The trust provided a list of other organisations with which they held service level agreements for the transfer of patients if required.

Surgery

Seven-day services

- Twenty-four hour consultant led care was in place; staff told us they contacted the senior medical staff when necessary and they felt well supported by the current on-call arrangements. Consultants undertook ward rounds on a daily basis. Formal buddy arrangements were in place to ensure consultant cover was consistent.
- Physiotherapy ran a six-day service with reduced hours on a Saturday and an on call system on a Sunday. We were told that patients admitted over the weekend would be seen by the on-call team of physiotherapists when required. Occupational therapy service ran a weekday service only.
- Pharmacy availability was on an 'on call' out of hour's process, including weekends. Access to all key diagnostic services was arranged in a timely manner 24 hours a day, seven days a week to support clinical decision-making.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Elective surgery was undertaken every weekday morning and afternoon at BMEC, with emergency theatre lists held between 5pm and 9pm. There was no elective surgery held at weekends. However emergency theatre lists were held between 8am and 8pm on Saturday and Sunday.
- Ophthalmic elective surgery was also performed at Sandwell Hospital on Monday, and Wednesday afternoons, Thursday and Friday mornings and both morning and afternoon on Tuesdays.
- Overnight care was provided at BMEC for patients who required specific ophthalmic care. Medical cover was on call only after 5pm, therefore patients requiring more urgent care would be transferred to a more acute setting.
- Medical staff were available on site between 9am to 5 pm; following which on call medical cover was in place. An ophthalmic consultant was on-call at all times including out of hours and at weekends and bank holidays.
- BMEC had an 'in-house' pharmacy which opened on weekday working hours, although shut for lunch between 1pm and 2pm. If medications were required out of hours, these could be collected from the City Hospital pharmacy on the same site.

Access to information

- Medical records were requested by the ward clerks and delivered to the wards. Patient records were paper based with nursing and medical notes recorded in separate folders.
- Local policies and procedures were available on the intranet for staff to access current care and management information. Staff showed us that these were easily accessible and new policies and procedures were highlighted on the front page.
- Discharge letters were handed to the patient to update their local doctor with a care summary. GPs had direct access to call the surgical services for advice over telephone.
- Medication changes, in particular those of older people with complex needs were communicated promptly to the GP by the telephone and letter including care home staff or domiciliary care staff when necessary.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Due to the forthcoming change to electronic patient records; surgical records had been moved from Sandwell Hospital, which is where ophthalmology patient records were stored, to an external storage and scanning company. We were told that within the four months since this process had started, there had been significant problems with obtaining patient records from this company in time for theatre lists, resulting in patients being cancelled. A process to deal with this had been initiated which was if missing notes were identified, the staff member would inform a manager and liaise with the medical records department to locate the records. Following a complaint received by a patient who's procedure was cancelled on the day it was scheduled for, theatre staff changed to cancelling patients where necessary 24 hours in advance to minimise disruption.
- We reviewed 21 patient records as part of the inspection, 20 out of 21 contained letters to the patients' GP outlining treatment given and discharge requirements.
- Staff told us they could access required information such as policies, guidelines and training updates through the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw consent forms signed and dated prior to surgical procedures being carried out. We heard that on

occasion a two or three patients a week attended planned admissions unit with their consent not signed; the surgical team rectified this as soon as possible before attending theatre.
- Between January 2016 and December 2016, the trusts consent audit report showed that of 7384 patients, 17% of patients were consented on the day, however it was identified that some patients did sign consent on the day, following specific admission guidelines. This report also identified that 80% of patients received an information leaflet to consider the operation proposed, a report conclusion recommended that the trust should consider amending consent forms to be clearer about signatures for the provision of information, receipt of information and consent for procedures.
- Staff had a good knowledge of the Mental Capacity Act 2005 and the process to follow when concerns were identified; staff attendance at training was 100%, as part of the safeguard training programme.
- Arrangements were made when referral to receive psychiatric support was identified either in the community or as an inpatient.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Patients told us that they had consented to different aspects of treatment, and felt that this had been well explained prior to staff starting any aspect of care.
- We saw every set of records contained signed consent forms. The majority of these were legible. Less than half the records viewed were ticked to confirm whether or not the patient had taken a copy of the consent form.
- We saw that 81% of BMEC medical staff were trained in 'basic consent' as per mandatory training requirements. However nursing and other clinical staff were not highlighted as having completed this training.
- Staff displayed good understanding of reasons why a patient may lack capacity and when a deprivation of liberty assessment may be required.
- We saw within patient records that all patients had a completed consent form documenting that the procedure they were due to undertake had been explained. We saw that where it was identified that a patient lacked capacity to consent to treatment, an alternative signature had been sought, for example by next of kin.
- We saw evidence of two incidents whereby a Deprivation of Liberty Safeguard (DOLS) could have been assessed for application. We asked the trust if a DOLS had been applied in these cases, following a capacity assessment. They responded that the patients did not have a DOLS applied at the time of these incidents. The trust reported that training and awareness for DOLS applications will ensure these situations are assessed, and where appropriate DOLS applied.
- We saw that training for DOLS was provided within a ward meeting held in March 2017 for inpatient staff.

Are surgery services caring?

Good

We rated caring as good because:

- NHS Friends and Family Test response rate was better than the England average. Results had been variable between 73% and 97% but more recently ranged between 93% and 98%
- Patient care experience had been positive and those we spoke with described staff as friendly and helpful
- Patients were fully informed about their care and felt involved in making decision about their treatment
- Patients we spoke with told us that the staff had been very good at alleviating pre-operative nerves.
- Staff treated patients with dignity and respect and presented as consistently caring.
- We saw staff interact meaningfully with both patients, and their families or carers in order to involve all relevant people in the care and treatment of the patient.
- BMEC employed a liaison officer to support patients with various aspects of coping with their eye condition.

Compassionate care

- The NHS Friends and Family Test response rate between January and December 2016 for surgery at City Hospital was 34%, which was better than the England average of 29%. Friends and family test performance was generally worse from May 2016 to December scores ranged between 73% and 97% however November and December scores improved between 93% and 98%.
- In the January 2017 patient experience survey at City Hospital, 100% of patients reported receiving sufficient information about their procedure, being greeted by

friendly theatre staff and their privacy and dignity was maintained. Twenty-six of the 33 responders reported their experience was better than expected, with seven responders reporting their experience to be as expected.
- Patients care experience had been positive; those we spoke with told us that staff were friendly, discreet and helpful.
- We saw staff asking for permission to enter an area where privacy curtains were being used protecting the patient's privacy and dignity.
- Patients in recovery were greeted on arrival; we observed them being reassured that the operation was over and they were told who would be looking after them.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We observed that staff treated patients in a caring and compassionate manner, remaining respectful at all times.
- We saw staff engage and interact meaningfully with patients, using patients preferred name and demonstrating relevant and personal knowledge of patients, such as preferred drink choice.
- Patients were assessed in large, private and spacious consulting rooms ensuring dignity and privacy were maintained at all times. We saw curtains pulled around beds within the recovery and post-operative areas.
- All patients we spoke with told us that staff were kind and polite, and they felt fully cared for throughout their time in BMEC.
- Data from the trust showed 2901 responses had been received for the Friends and Family Test (51%) between April 2016 to March 2017. These showed that 89% would recommend the service to their friends or family.
- Staff used an iPad to capture patient feedback about the care they had received.

Understanding and involvement of patients and those close to them

- Patients who had undergone surgery told us they were aware of the procedure that had been carried out; they knew their post-operative plan and planned discharge date. All the patients we spoke with told us they were aware of what was happening to them; they told us they felt involved with their care.
- In planned admission, patient's surgery was explained to them, including the post-operative plan of care and expected length of stay. Patients told us they had been given opportunities to ask questions and seek clarification, they felt safe and the staff had alleviated any of their fears.
- One relative we spoke with told us they thought the staff were friendly and took time to speak with the patients.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Patients told us they felt fully informed about their care and treatment. Patients told us they felt their surgery options had been explained clearly, and that they had had sufficient time to ask any questions.
- We saw that staff interacted respectfully with family members and other visitors, allowing visitors who had arrived a few minutes early to see their relative rather than having to wait outside in the corridor.
- Staff gave examples of where they had recognised when involving a patient's family would be supportive to care and treatment, such as if a patient had a learning disability or was living with dementia.

Emotional support

- The staff we spoke with told us they would inform the consultant when a patient showed extreme anxiety prior to surgery; they would ensure that they met with the patient prior to the surgery.
- The staff told us they gave the patients sufficient time and opportunity to discuss their concerns and answered their questions to allay their fears. Patients we spoke with told us that the staff had been very good at alleviating pre-operative nerves.
- Counselling services were arranged when necessary through the consultant referral process or as an outpatient.
- A team of trained, hospital chaplains provided spiritual care to patients, staff and visitors of all faiths and none including a 24-hour emergency call out service. Chaplains and authorised chaplaincy volunteers undertook a regular programme of pastoral visiting to attend all wards and departments. Weekly communion services were held and all major faith festivals were celebrated, including Easter, Christmas, Eid, Vaisakhi and Diwali.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We saw that BMEC employed a liaison officer who attended the ward to support patients with concerns such as claiming benefits, registering as blind and other possible requirements. This service was well advertised on the ward.
- Staff we spoke with demonstrated a good understanding and awareness of the needs of an ophthalmologic surgery patient, particularly with regards to vision impairment. We observed staff to listen carefully to patients in order to understand their needs and we saw staff provide reassurance when patients needed extra support..
- We saw visitors were encouraged to stay with patients, particularly if a patient had additional needs such as a learning difficulty, in order to promote emotional support.

Are surgery services responsive?

Good

We rated responsive as good because:

- Between October 2015 and September 2016, the average length of stay for surgical elective patients at City Hospital was 1.7 days, compared to 3.3 days for the England average.
- Patients were booked to attend the department two to three weeks prior to the operation date to discuss their individual needs and meet with medical staff if required.
- For the period March 2015 to December 2016, the trust cancelled 905 surgeries. Of the 905 cancellations, only five were not treated within 28 days.
- Between January and December 2016, the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been better than the England overall performance for the whole period with a stable trend.
- Translation services were easily accessible.
- Complaints were dealt with appropriately and staff were aware of the learning from complaints to improve the service for other patients.
- We were told by patients at BMEC that waiting times for pre assessment and surgery was low, and appropriate for their needs.
- The service sought to work effectively with patients' individual needs.

However:

- December 2016 showed that 78% of patients were treated within 18 weeks of referral which was above the England average of 73%. However the national indicator is 90%.
- Wider learning was not promoted through complaint trends being shared amongst all areas of the trust.
- Operations had been cancelled for patients at BMEC due to records not being within the unit on time which meant patient care and treatment was delayed.

Service planning and delivery to meet the needs of local people

- Between October 2015 and September 2016, the average length of stay for surgical elective patients at City Hospital was 1.7 days, compared to 3.3 days for the England average.
- Between October 2015 and September 2016, the average length of stay for surgical non-elective patients at City Hospital was 3 days, compared to 5.1 for the England average.
- Patients were booked to attend the pre-assessment department to prepare for their procedure. Staff recorded the necessary information, ensuring each individual was medically fit to undergo the surgery. Patients were booked to attend the department two to three weeks prior to the operation date to discuss their individual needs and meet with medical staff if required.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- BMEC delivered surgical services in a standalone building within the City Hospital site, and also at Sandwell Hospital this enabled local patients to receive treatment at the most convenient location for them.
- Staff told us they delivered very specialist ophthalmic surgery therefore enabling patients with complex conditions to be treated at the centre.
- A pre-operative assessment clinic was held for patient within the day surgery inpatient unit.

Access and flow

- The senior nurse on duty took on the role of site meetings and worked alongside the capacity manager, organising bed moves and patient discharges, during the capacity meetings. Meetings took place three times a day; data was collected to identify the escalation level.

- Admission processes varied depending on the planned surgery. Day surgery patients, admitted in the planned admission unit, sat on chairs in the waiting area, walked to theatre and were then brought back to the unit on a trolley. Inpatients requiring an overnight stay or longer were admitted to the ward with an allocated bed. Should a day patient require an overnight stay the staff raised this with the capacity manager at the earliest opportunity.
- Discharge arrangements followed the trusts policy and procedure. Patients left the hospital with a discharge letter, take home tablets and advice sheets. Where possible relatives escorted patients home or transport was arranged.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient had not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. For the period March 2015 to December 2016, the trust cancelled 905 surgeries. Of the 905 cancellations, only five were not treated within 28 days.
- Between March 2015 and December 2016, trust level, cancelled elective operations, were similar to the England average. From March 2015, the rates fell for two quarters before rising above the England average in September 2016. Weekly planning meetings have been refocussed to ensure robustness of booking admissions and individual speciality challenge and confirm discussions.
- Between January and December 2016, the trust's referral to treatment time (RTT) for admitted pathways for surgical services had been better than the England overall performance for the whole period with a stable trend. Data for December 2016 showed 78% of this group of patients were treated within 18 weeks versus the England average of 73%. General surgery data showed that 91% of patients were seen within 18-week referral time.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Patients were referred to BMEC through other healthcare professionals such as their GP therefore all patients were seen on an appointment basis.
- Patients received a pre-operative appointment prior to a date for surgery to check for suitability. On the day of surgery, day-case patients waited within an ambulatory care waiting room on the ward and walked to theatre if they were able. Following surgery, patients would wait within the recovery area until they were ready to return to the ward area. Patients were given a letter which was also sent to their GP which detailed discharge information including medication needs, and any follow up appointment requirements. Inpatients were allocated a private side room on the ward.
- Staff told us that they had not had any problems with regards to ward bed space for managing in patients.
- Emergency ophthalmic surgery had specific scheduled times in the evening of every week day, and between 8am to 8pm on weekends. Should a patient urgently need surgery during the week day, they were placed on the elective theatre list.
- Data from the trust showed ophthalmology as a whole had a referral to treatment time rate of 81% which was higher than the England average of 78%.
- Patients we spoke with told us they had not had to wait long from referral to surgery.

Meeting people's individual needs

- Translation services were easily accessible. National interpreter services were requested as required and the availability of a dual handset was used to support patients and their relatives.
- Staff were seen promptly attending to patients when they used their call bells.
- We were told that patients with learning disabilities were prepared for surgery by visiting theatre area if required and pre-meeting the relevant staff. Carers were encouraged to attend with the patient and remain with them during the process.
- Bariatric equipment was readily available and the staff experienced no delay in receiving beds, chairs and moving equipment when ordered for a specific patient.
- Disability access and support was considered for each individual and made available when necessary.
- Special arrangements were in place for people with a learning disability for example; in theatre, a patient was given time to attend the department to meet with staff and talk about what happens on the day of surgery. Patients were encouraged to bring a carer to support them during their appointments.

- The service supports people with other complex needs with accessible wards and entrance to the hospital, clear signage and support from volunteers was arranged when attending without a carer.
- Two registered learning disability nurses supported those patients being cared for in the trust. Specialist learning disability services were contracted in when required.
- A dementia screening tool was used to support patients admitted to the hospital to identify and support the assessment of their care needs. The trust employed a dementia lead nurse who was available to support the ward staff when necessary.
- Dementia care pathways had been introduced and 'this is me' booklet was in use for patients with dementia. The booklet was given to relatives to complete to document of their patient history including individual likes and dislikes.
- Staff in day ward told us that patients with dementia attended with a carer. They would seek guidance from them to support the patient with their care and treatment.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Staff told us that interpreters would be booked for patients who required translation services for appointments. This was a face to face interpreter service, with telephone translation also available.
- We saw there were a good supply of patient leaflets available and that patients were given written information prior to and after their surgery.
- We saw patient information leaflets available in large font and braille.
- Data from the trust reported that adaptations within BMEC had been made to support visually impaired patients. For example, consent forms were black type on yellow background as recommended by the Royal National Institute of Blind People (RNIB).
- Adapted equipment was available for patients that required this. For example, portable lamps were available to use with bariatric patients, or patients who would be unable to sit in an enclosed area.
- Consulting rooms on the inpatient / day ward were large and spacious therefore allowed access to patients using wheelchairs or bariatric patients.
- Staff provided examples of occasions where specialist staff attended to support patients during treatment, such as learning disability specialists. We saw the service used magnetic symbols that were attached to patients' beds to alert staff to any specific needs such as individuals diagnosed with dementia or patients at risk of falls.
- We saw that patients were offered a wide range of menu options, which took into account dietary requirements, such as halal, vegan and vegetarian, and gluten free hot and cold meals.
- Staff told us about managing the discharge of patients who required extra social care and support; examples were given of specialist staff attending to assess patients such as occupational therapists, and liaison with local authorities to arrange care packages.
- Inpatient beds were placed within individual bays therefore ensuring male and female patients had privacy.

Learning from complaints and concerns

- Staff told us they would know if there were a complaint made on their ward but did not get to hear about other wards complaints, which meant that wider learning was not promoted.
- Between April 2016 and March 2017 there was 84 complaints received for surgery at the trust. The main issues related to attitude of nursing staff, communication and dietary requirements. We were told that no complaints were currently outstanding for surgery at this site. The CCG told us that they felt the trust responded well to any concerns raised with them.
- We saw Patient Advise and Liaison Service (PALS) notices encouraging patients and relatives to contact them should they wish to raise any issues about their care and treatment.
- Between June 2016 and November 2016, 16 contacts were made with the PALS, of those only one complaint was formalised, other contacts were satisfied with their response. PALS offered confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- From January to December 2016, two complaints were received regarding surgical services at BMEC. One related to incorrect discharge information, the other

about miscommunication. Both complaints had been upheld. Managers discussed these complaints with us and described how an appropriate investigation process had been followed.
- Staff told us about learning from complaints; for example, ensuring patients were informed of cancellations at least 24 hours in advance rather than on the same day. We saw that information regarding staff updates was shared during team meetings and quality improvement half day meetings.
- Staff told us how they dealt with verbal complaints received on the ward, such as relating to televisions not working or patients having too many visitors and this being raised with them. Staff discussed how they sought to de-escalate these concerns through listening to patients and responding accordingly.
- We saw the trust had a complaint policy due for review in April 2017, this was accessible through the staff intranet.
- Patients we spoke with told us they knew how to make a complaint if they wished to do so.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Staffing vacancies and the use of agency staff caused anxiety for permanent staff. Staff told us that they when they were extremely busy on the wards staff breaks were missed.
- A number of staff were unsure that the recent ward moves and the bed reconfigurations were necessary and in the best interest of the service. They were unsure of the trust vision.
- Staff felt that the future trust plans were not cascaded to the ward staff.
- Staff morale at BMEC was low in some areas such as theatres following workforce changes and restructure.

However:

- Staff told us that their matron was visible and supportive.
- Staff told us that their intranet shared information with the staff, working across both sites, to update them on recent events.
- We heard that many professional and committed staff worked within surgery, putting the patient first.
- The local leadership of BMEC presented as supportive, visible and open. Staff spoke positively about the support they received.
- Staff were required to engage regularly with information days and team meetings.

Leadership of service

- The trust's operational management structure was in place to provide high quality clinical leadership, putting clinicians at the heart of decision-making. Each division and clinical directorate was managed by a 'triumvirate leadership team' comprising of a doctor, a nurse/lead professional and a manager. This three-tier management structure was mirrored in all areas of the management team.
- The head of nursing, a group director and group director of operations led surgical services at City Hospital. One director managed specialist services such as vascular, general and ENT. In theatre, the team was a clinical director, matron and general manager.
- Staff told us that their matron was visible, supportive and assertive in addressing any issues that arose. Management above the level of matron was rarely seen on the wards.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- BMEC was managed by a general manager, a lead nurse and a clinical director who reported to the trust's surgical services directorate management team.
- Theatre managers and a ward manager ran the day-to-day business of the BMEC surgical services.
- Staff told us that management within BMEC were visible and supportive. The lead nurse was seen several times a week, and the managers of the theatres and ward were based within these areas therefore easily accessible to staff. However, staff told us they rarely saw members of the executive team with the exception of the time period following the work force changes. The workforce changes resulted in surgery staff being re-interviewed for their posts with the potential result of keeping their post, being re-banded to a lower grade or losing their job. At this time, staff reported they saw two members of the executive team in relation to the negative impact that the workforce changes had upon staff morale.
- Staff told us they felt local BMEC management kept them informed regarding changes to the service; but felt

some, such as work force changes, had been made by more senior management within the trust without providing consultation beforehand; therefore these changes seemed imposed upon staff, rather than a collaborative process.

Vision and strategy for this service

- We spoke with a number of staff who were unsure that the management of the surgical services was effective; including the recent ward moves and the bed reconfigurations. Staffing shortages and use of agency staff caused anxiety for some permanent staff. The future of the City Hospital service was described as uncertain due to the new site opening and poor communication to update the staff on future plans.
- Staff told us they were aware of the trust values but currently less sure on the vision.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- BMEC had the following vision: "To deliver a high quality locally, regionally and internationally acclaimed, research driven service for all ophthalmic specialties in the management of acute and chronic disease."
- The trust as a whole had a "2020 vision" and nine values or "care standards". Staff we spoke with were aware of the 2020 vision, and although were not able to quote the nine values verbatim, were able to demonstrate a good understanding of what these were, and how they related to patient care. We observed staff working in line with the trust values when interacting with patients and colleagues

Governance, risk management and quality measurement

- Surgical services group management board were responsible for reviewing surgical procedures. Minutes of monthly meetings were seen to review governance at a glance, finances, performance and work force. Previous minutes were discussed and reviewed at each meeting.
- Surgical services in the trust maintained their own risk register. The first priority on City Hospital, surgery risk register, focussed on the risk of patients receiving compromised surgery due to power failure, as there is no uninterruptable power supply in the event of a power failure. Contingency procedures were in place so that the patients undergoing surgery would be manually ventilated. Suspension of all elective surgery would occur until power supply restored. In the case of life or limb threatening surgery surgeon, anaesthetist and theatre team to assess whether to proceed. Estates had been allocated finance for this issue and it was planned to be rectified by end of April 2017.
- There were 27 risks on the register, which was up to date and reflected the risks across surgical services. Each risk had a responsible person allocated, with a review date identified. The oldest risk on the register was listed as May 2016.
- Ward staff we spoke with were unsure about the risk register within surgery; staffing vacancies and the use of agency staff was their concern. Theatre, staff were aware of the risk register and their issues; this included the lack of audible sound in the recovery area, for use of the emergency call bell. Senior staff knew how to access risk register. Risks were inputted on the electronic risk register with further shared learning being discussed in QIHD.
- Staff told us they received feedback from their manager when an incident was reported and an automatic email feedback was received when an incident was closed.
- The trust had a quality and safety plan for 2016-2019 which had an outcome to aim to be among the best in the NHS. They aimed to reduce deaths in hospital that could be avoided, such as sepsis, so that they were among the top 20% of comparable NHS Trusts in the UK.
- The matron compiled monthly exception reports to identify early issues with specific indicators, including nursing staff indicators, management and leadership indicators and quality and safety indicators. Depending on the findings, local action was taken when appropriate or escalated to the senior management teams or group director. We saw January 2017 report which identified the indicator findings. For example, we saw that there had been no formal complaints, audit results were documented, Friends and Family Test results were monitored and the top three key risks were identified.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We saw a surgical risk register which contained risks specific to ophthalmology. Two were very specific in relation to surgery; however several risks affected more than one area within ophthalmology such as ED and theatres. Risks included potential information loss; performance with regards to booking patients; lack of capacity for neuro-ophthalmology and glaucoma

services; and concerns regarding medical staffing. We saw that these risks had been reviewed between December 2016 to January 2017and had specific action plans in place and were reviewed regularly.
- We saw minutes from clinical governance board meetings for the surgery 'A' directorate under which ophthalmology sat. These minutes spanned from November 2016 to January 2017 and demonstrated that ophthalmology services were represented by the lead nurse, and discussed at each meeting. The minutes also discussed audits, never events, the clinical effectiveness report, risk register and serious incidents across the directorate to allow shared learning and discussion.
- We were told that learning and updates from within the surgery directorate was shared at quality improvement half day (QIHD) meetings held ten times a year with all available staff from the area or directorate. We saw minutes from February and April 2017 QIHD which confirmed what we were told.

Culture within the service

- We found that staff in the surgical services were professional and committed to putting the patient first. Several staff described themselves and their colleagues as friendly and good communicators.
- We found that staffing vacancies could lead to staff behaviours exhibiting anxiety and stress and staff sickness and turnover were affecting the ward staff morale. Sickness rates for City Hospital surgical nursing staff varied between 4% and 20%. Nursing turnover rate varied between 2% and 31%.
- Theatre staff had promoted the philosophy 'it's ok to challenge'. Windows of risk were discussed at team meetings to identify and prevent preventable harm. Any identified issues were emailed to all staff and discussed in the team brief.
- Staff told us they had attended a DoC meeting describing the requirements of staff and mangers to be open and honest when things went wrong.
- Staff told us that they were extremely busy on the wards and occasionally staff breaks were missed. This led to staff feeling tired although they believed they still ensured patients were safe and well cared for.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Culture within the service was varied between staff working within theatres and staff working within the inpatient/ day patient ward. The staff had recently undergone work force changes in September 2016 which had resulted in the re-banding of several band 6 staff to band 5, some staff members being made redundant or redeployed, and the closure of a ward to make a combined inpatient and day-case ward.
- Staff within the inpatient ward reported that, whilst this initially had a negative impact on staff morale, the staff were now feeling more positive and settled within their roles and felt morale had improved.
- Staff within the theatre department reported that morale was still low and the effect of these changes was still being keenly felt. In particular, staff commented upon the difficulty of providing safe patient care consistently when presented with vacant staff positions and long term sickness related absences. We saw that staff morale was discussed as part of April 2017 QIHD, and plans for support from the executive team were highlighted.

Public engagement

- The trust's chief executive told us they were committed to delivering safe, effective care, recognizing and promoting the principles of equality, diversity, and non-discrimination. They promoted mutual respect and tolerance for each other's beliefs and backgrounds, regardless of race, gender, sexuality, religious beliefs, or age.
- All patients were encouraged to give feedback about their experience and engage with the trust at every opportunity. Managers told us that the trust welcomed any feedback so that they knew what worked and what improvements they needed to make. The trust website clearly signposted patients and relatives to give their earliest feedback where possible.
- Patients and local people were encouraged to get involved in the hospital by becoming a member of the trust. 'You said', 'we did' posters were displayed showing what patients had reported and how it had been addressed. For example, patients said they were unsure of discharge arrangements and now this discussion had been included in the daily progress review with each patient.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- BMEC had a comprehensive website with a wide range of information to aid patients and carers to understand services provided by BMEC. BMEC also had a presence on social media, such as Twitter, to enable communication with the public.
- Every department within BMEC had photographs of its staff on display in the waiting area. The photographs included each staff member's name and their job role.
- We observed age specific feedback was sought from patients and parents on the day surgery unit using a personal computer. This was a new initiative which had not been reported on at the time of our inspection.

Staff engagement

- Staff told us that their intranet shared trust information to update them on recent events across both sites. Some information was available as a paper version.
- When issues were raised staff told us they felt listened to but was less positive that action would be taken. For example, staff shortages and pressure to admit patients to avoid cancelling surgery was raised but continued to occur.
- Ward staff felt they were not always included in plans for surgery and their opinion was not sought. However, we were assured that progress with updating staff about the new site and staffing structure was imminent.
- The chief executive sent out a weekly message to staff in paper format and electronically.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- Staff told us about the quality improvement half days (QIHD) which provided opportunities for staff to meet as a team or a directorate 10 times per year to hear trust wide messages and directorate training and updates. Staff reported that these were positive meetings whereby all elective work across the trust was not scheduled to allow maximum attendance; however some staff stated that due to shift patterns or emergency work, they were not always able to attend. Managers told us, and we saw, minutes and PowerPoint presentations from the events were available on the intranet.

Innovation, improvement and sustainability

- In theatre, a communication tool had been introduced as a local intranet page accessed by all staff and users. This communication tool promotes consistent, timely information to all staff and users within the theatre department.
- Health promotion care plans were being gradually introduced on to the surgery wards to promote individuals general health, alongside their surgical procedures.

Birmingham Midlands Eye Centre (BMEC) Surgery:

- We saw that the theatres team at BMEC had won an award for excellent adherence to the World Health Organisation (WHO) five steps to safer surgery checklist in 2015.

Services for children and young people

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

Information about the service

Birmingham Midland Eye Centre, part of Sandwell and West Birmingham Hospitals NHS Trust provides care and treatment for children and young people, aged nine months to 18 years, with ophthalmic conditions. It is located at the Birmingham City Hospital site, and operates on weekdays between 8am and 5pm. Scheduled operating theatre lists for children and young people are confined to Mondays and Thursdays only. Surgery takes place within the Birmingham Midland Eye Centre operating theatre department, with a dedicated recovery area for children and young people separated by screens from the recovery area used by adults.

There are five beds or cots located in a children's ophthalmic day surgery unit (DSU) aligned to the adult ophthalmic day surgery unit. Children and young people requiring overnight stays are admitted to the children's ward located on the main Birmingham City Hospital site. We did not visit the main hospital site as part of this inspection.

Non-surgical diagnosis and treatment of children and young people's eye conditions are provided in predominantly adult based areas at Birmingham Midland Eye Centre, in the outpatients and emergency departments. These services were inspected and have been reported in more detail as part of the surgery, emergency department and outpatient and imaging services within this report.

Children and young people at Birmingham Midland Eye Centre are cared for by specialist eye doctors, paediatric anaesthetists, ophthalmic trained adults' and children's nurses, operating department practitioners, allied health professionals and support staff. Pre-operative assessment is undertaken by the children's nurses to provide expert knowledge and continuity of care. Paediatric anaesthetists are present for all surgical procedures for children and young people and are booked in advance to ensure their attendance. Young people at 16, still in education, are offered the choice of adult or paediatric care.

Our inspection team included a CQC inspector, consultant paediatric ophthalmologist, a nurse, and an expert by experience with personal experience of using and caring for someone who used the service.

During our inspection we visited the day surgery unit DSU, operating theatre, emergency department, and outpatients and diagnostic imaging departments at the Birmingham Midland Eye Centre. We observed how patients were being cared for, spoke with nine children and young people who used the service and five parents. We looked at 11 children's personal care and treatment records, and reviewed documentation provided by the trust including performance information.

We also spoke with 24 members of staff including the executive and clinical leadership team, ophthalmology consultants, consultant anaesthetists, nurses, orthoptists, operating department staff, eye clinic liaison officer and administrative staff.

Services for children and young people

Summary of findings

Overall we rated this service as Requires Improvement because:

- Children's and young peoples' services were delivered in a predominantly adult environment. There were no separate children and young people waiting areas. designated play areas, or children's toilets in the day surgery unit (DSU) emergency department, or outpatients' department.
- Staff, including the leadership team, were unclear about the immediate plans and strategy and priorities for the children and young people service.
- Staff told us they would like to see greater recognition and support of the children and young people service from the executive leadership team. They described a lack of formal interaction with the trust board. Staff felt the executive team had not been visible and could not recall when they had last visited the service. However, in 2016 the trust created a CYP Board working across services, with a dedicated CYP champion, separated from the paediatric team management structure. Staff told us there had been some recent improvement with increased engagement with medical staff, particularly consultants.
- Medical staffing levels fell below national standards, particularly consultant staffing. There was no seven day cover from a consultant paediatrician and no agreed plans to increase the number of paediatric ophthalmology consultants.
- There is a risk that children, particularly those younger than three years of age, who attend the emergency department at the Birmingham Midland Eye Centre with an emergency eye condition, do not receive either timely or appropriate treatment due to limited availability of specialist medical staff and anaesthetists.
- There was no separate storage of adult and children and young people emergency medicines and equipment.
- Surgical lists for children and young people were scheduled on Mondays and Thursdays only. The non-surgical service did not run at evenings or weekends which reduced accessibility.
- There was no evidence to demonstrate that staff had completed paediatric life support training, with the exception of three children's trained nurses and one paediatric anaesthetist we spoke with. The leadership team identified their highest risk was there was no guarantee there would be a paediatric anaesthetist available for out of hours cases, or emergency cases, or for days when elective surgery was not taking place.
- Children and young people friends and family test results were not reported separately, this meant that there was limited opportunity to act on patient feedback to improve or change the service.
- In the Birmingham Midland Eye Centre emergency department, we saw people overheard consultations with other patients due to the open plan layout.
- Risks to the service were not always mitigated or acted upon in a timely manner and largely remained unresolved.
- The trust were unable to provide or report on separate mandatory training for the children and young people's service as it was part of the (adult) ophthalmology service within the surgical directorate. This is because the trust did not collate the data in this format. This has therefore been reported in the surgery department core service report.

However, we also saw examples of good practice :

- Nursing staffing levels in the DSU met the Royal College of Nursing (2013) Standards for Staffing Levels in Children and Young People's Services.
- The environment was clean, infection rates were low, and staff complied with infection prevention and control practices including hand hygiene and arms bare below the elbow.
- The service had effective systems in place to ensure the safe supply, storage and administration of medicines.
- Records were securely stored and maintained in in accordance with national and local standards.

Services for children and young people

- Staff used an age specific paediatric early warning system (PEWS) to observe for clinical deterioration and appropriate action was taken as a result of the findings.
- In the operating theatre, there was a dedicated recovery area for children and young people separated by screens from the area used by adults.
- A recently introduced one stop pre-operative clinic helped to reduce the number of hospital appointments patients needed to attend.
- Extended role training was underway to manage a range of new and follow up patients in allied health professional led clinics. This was designed to deal with the high volume of patients.
- There was access to a multi professional health care team within Birmingham Midland Eye Centre who worked collaboratively to understand and meet the range and complexity of children and young people's needs.
- Interactions between staff and patients were individualised, caring and compassionate and children and young people and parents felt they were treated with dignity and respect.
- Staff understood the trust's safeguarding policy and had access to a named safeguarding lead nurse. Staff were provided with mandatory safeguarding training at a level appropriate to their job role.
- Parents were involved in their child's care and treatment. We saw staff spoke with children and young people in a way that enabled them to gain a full understanding of their treatment plan and take an active role in decision making.
- Staff told us nursing and orthoptist leaders were supportive, visible and accessible.
- The orthoptist team had introduced a formalised audit programme, and were working towards the introduction of allied health professional led clinics.
- Staff attended monthly quality improvement half days, which addressed areas that required improvement, and encouraged reflection on how clinical delivery could be improved.
- During our inspection staff told us they felt there had been some improvements in engagement between medical consultants and the executive management team within the previous month, since the new team had taken up post.

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Medical understaffing was an identified risk. Consultant cover did not meet national guidance.
- There was no guarantee for out of hours cases, or emergency cases, or for days when elective surgery was not taking place that the operating department staff on duty had paediatric life support training. However, the trust told us that there is always a paediatric anaesthetist available on the Birmingham City Hospital site.
- There was a mix of paper and electronic records which meant they were not always unified and there was difficulty with access to notes.
- Emergency resuscitation equipment for children and young people and adults was not stored separately. The trolleys were described by staff as "overstocked", "packed" and "full" and staff told us this could make it difficult to locate equipment. We saw this to be the case in all of the areas we visited.
- There was an absence of evidence to demonstrate that paediatric life support training had been provided or completed. The trust provided data on basic life support only, and were unable to distinguish between paediatric and adult life support or isolate particular staff who worked with children and young people, as all staff worked with both adults and children. We saw medicines to be used in emergency treatment of anaphylactic (serious allergic) reactions were available in pre-filled syringes. However, there was no supply of separate syringes containing children's dosages. Staff did not have written instructions to refer to in those circumstances.
- The ambient room temperature of medicines' storage areas in the outpatients, emergency department, operating theatre and day surgery unit was not monitored.

However, we also saw examples of good practice

- Nursing staffing levels in the day surgery unit (DSU) were consistently in accordance with the Royal College Nursing (2013) Standards for Staffing Levels in Children and Young People's Services.
- The environment was clean, infection rates were low, and staff complied with infection prevention and control practices including hand hygiene and the arms bare below the elbow policy.
- Staff applied effective systems to ensure the safe supply and administration of medicines.
- Records were generally securely stored and completed in accordance with national and local standards.
- Pre-assessment clinics enabled risks to be identified prior to the day of surgery and were acted upon in a timely manner.
- World Health Organisation (WHO) Safer Surgery surgical safety checklists were completed
- Staff observed for clinical deterioration following surgery using a nationally-recognised, age-specific paediatric early warning system (PEWS). Where applicable, action was taken as a result of the findings.
- Managers encouraged openness and transparency about safety. Staff understood their responsibilities to raise concerns and report incidents. Learning from incident investigations was shared with staff in a timely manner.

Incidents

- Staff told us they reported incidents on-line using the trust's electronic reporting system. Reported incidents were then discussed at staff handovers and staff meetings.
- Records we looked at showed staff reported a total of 86 incidents in ophthalmology from October 2016 to December 2016. Sixty-five of the 86 reported incidents were patient safety incidents. Ten of the incidents were classified as near miss, 59 classified as no harm, 13 as low harm and four moderate (short term) harm.
- Out of the 86 reported ophthalmology incidents nine applied to children and young people: one was classified as a near miss where staff had been unaware of a patient's latex allergy. Five incidents were classified as low harm, and three as no harm. Themes which emerged were staff had not correctly followed procedures for booking appointments, a delay in the start of the operating list due to the first patient being late, and missing patient information, for example, notes, no referral letter and staff not being informed of a child being transferred from another hospital.
- The trust reported to the NHS Strategic Executive Information System which records serious incidents and never events. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between February 2016 and January 2017 there were no reported never events in the children and young people service at Birmingham Midland Eye Centre.
- Staff reported medicine incidents directly to the Medicine Safety Officer and the Chief Pharmacist. The level of harm and any trends in repeated incidents were identified and discussed at a trust wide the medicine safety group and the patient safety group. Staff told us that learning from incidents was undertaken and practice changed where necessary to prevent them happening again. Staff told us learning from trust never events was shared by e mail and in the quality improvement half days. An example of changes made as a result of the learning was to introduce an improved process for checking patients' identity in the outpatients department, before staff administered medicines, we saw this change was embedded and worked well in practice.
- Staff were able to describe the basis and process of duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff told us they could not recall any incidents where it had been necessary to apply the duty.

Cleanliness, infection control and hygiene

- The children and young people service had established procedures in place to enable effective infection prevention and control. These were based on the Department of Health's Code of Practice on the prevention and control of infections and related

guidance, 2015. They included guidance on hand hygiene, use of personal protective equipment (PPE) such as disposable gloves and aprons, and management of any spillage of body fluids.

- All patient areas we inspected were visibly clean and tidy including treatment and waiting areas. Clinical waste, including sharp objects, was disposed of safely. We saw clear segregation of storage of clean and dirty equipment.
- We saw equipment identified as being clean by the use of green 'I am clean' labels.
- The trust reported two cases of hospital acquired MRSA from January 2016 to December 2016. Neither of the two cases happened in the children and young people service. There were no other reported hospital acquired infections within the same period or between October 2016 and March 2017.
- National Institute of Health and Health Care Excellence (NICE) quality statement 61 details that people receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. During our inspection we saw that handwashing sinks, hand sanitisers and soap were readily available and clearly signposted, and were consistently used by all staff. We also observed that all staff were bare below the elbow throughout our inspection and used PPE in accordance with national and local guidance.
- Staff followed cleaning instructions and correctly described the processes they should apply.
- Hand hygiene audits were completed monthly in all clinical areas. We reviewed reports of the audits carried out in the DSU between January 2016 and January 2017 and saw a 100% compliance score was achieved every month except for November 2016 when the audit was not reported upon. Compliance rates in the orthoptic department between July 2016 and February 2017 ranged between 96% and 99%. Hand hygiene audits carried out in the operating theatre department, outpatients department and emergency department at Birmingham Midland Eye Centre have been reported in the relevant sections of this report.
- All waste bins we saw were foot-operated and clean. Waste was separated in different colour bags to signify different categories of waste. This was in accordance with Health Technical Memorandum HTM 07-01, control of substances hazardous to health and health and safety at work regulations.

Environment and equipment

- The service had identified that the facilities for children were in need of improvement. We saw adults and children waiting in the same area in the emergency department as there was insufficient waiting space for both children and adults We also saw a lack of storage space in the DSU and emergency department.
- The 2016 Patient-Led Assessment of the Care Environment at Birmingham Midland Eye Centre reported 'condition, appearance and maintenance' of the building score as 97% for the trust, better than the England average score of 93%.
- There were no dedicated children's play areas, children's toilet facilities, or separate waiting areas in the DSU, emergency department or outpatients department. In the operating theatre there was a dedicated recovery area for children following surgery. This was separated by screens from the recovery area used by adults. This met the requirements of the Royal College of Anaesthetists Guidelines for Provision of Anaesthetic Services (GPAS) 2016. We saw parents were invited into the recovery area once the patient's clinical condition allowed.
- There were no consulting rooms designed specifically for children in the outpatients department. There was one consultation room in the emergency department which was allocated for children and young people. Staff told us that appointments would be scheduled to ensure that no other consulting rooms were used.
- There was an electronic key fob entry system for authorised personnel to gain access to the main entrance of the children's DSU. We saw the doors remained securely shut and the key fob entry was always used during our inspection.
- Staff knew how to locate all emergency equipment, and maintained a register of checks which showed equipment was checked on at least a daily basis and the required equipment was in place and in date.
- Resuscitation trolleys were located at appropriate intervals throughout Birmingham Midland Eye Centre. However, we saw in all clinical areas we visited that emergency resuscitation equipment for children and adults was not stored separately on the trolleys. Staff described the trolleys as "overstocked", "packed" and "full" and told us this could make it difficult to locate equipment. Our observations confirmed this was the case. Staff told us they had raised concerns about this.

The stock and layout of the trolleys was managed by the hospital's resuscitation team who had decided that all trolleys throughout the hospital should be identically stocked and set out for consistency.

- Staff told us they were satisfied they had sufficient and proper equipment to carry out their responsibilities and deliver effective patient care. All equipment we looked at was regularly serviced in accordance with manufacturer guidance and electrical equipment was PAT tested.
- We saw there was limited storage space in the children's DSU. However, the DSU was adjacent to the adult ophthalmic DSU and inpatient area, and we saw that storage space was shared between the two areas. Consumables and equipment designed for children were available and easily accessible.
- There was no separate play room for children within the DSU or any of the patient areas we visited. However, age appropriate wipe clean toys, including distraction activities, were stored in a designated toy cupboard in DSU. There were also some toys in the emergency department and outpatients department. Staff reminded parents to keep the areas tidy and free from clutter.
- We saw there was sufficient equipment available to meet children and young people's needs including equipment for use in an emergency. Staff we spoke with could not recall any times when there was insufficient equipment.

Medicines

- A medicines optimisation policy dated January 2016 detailed arrangements for prescribing, requisition, storage, administration and control of medicines in accordance with NICE guidance NG5: Medicines optimisation: the safe and effective use of medicines. This had been shared across the trust intranet to enable staff to have direct access. Staff we spoke with were able to locate the policy and recall its principles.
- All medicines were supplied and administered against an individual prescription by a doctor, and recorded on a medicines administration record (MAR). Staff told us no other method of supply and administration of medicines was used within CYP, such as patient group directions (PGDs). PGDs provide a legal framework which allows some registered health professionals to supply and administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.
- We look at 11 MARs in the DSU and saw they were all documented in accordance with local and national guidance. They showed that no prescribed medicines had been missed or omitted. Where applicable, allergies were clearly documented and acted upon.
- In all patient areas we visited we found medicines were stored securely in locked cupboards or, where applicable, in a pharmacy refrigerator. Refrigerator temperatures were monitored and recorded at least daily to ensure medicines were kept in optimal conditions. All the recorded temperatures were within the required range. However, the ambient room temperature of medicines' storage areas in the outpatients, emergency department, operating theatre and day surgery unit was not monitored.
- There was a new electronic key system to enable the security of medicines across the trust. Only authorised staff had access to medicine cupboards and the electronic system had the ability to track who had accessed medicine cupboards.
- Emergency medicines for resuscitation were stored on dedicated trolleys in all of the clinical areas we visited. This meant they were available for immediate use. However, they were not protected with a tamper evident label or seal to provide visible evidence that they were safe to use, as recommended in guidance issued by the UK Resuscitation Council.
- We saw medicines to be used in emergency treatment of anaphylactic (serious allergic) reactions were available in pre-filled syringes. There was no supply of separate syringes containing children's dosages. There were no accessible written instructions for staff to refer to in those circumstances. Staff told us that in the event of such an emergency the dosage of the medicines would be scaled down accordingly, on the verbal instruction of the doctor in charge.
- The Royal College of Nursing Standards for the weighing of infants, children and young people in the acute health care setting states all children and young people should be weighed on admission to allow for accurate calculations of medicines. In all 11 records we looked at, we saw children and young people had their weight recorded and prescriptions were appropriate for the child's weight.

- Arrangements were in place to check medicines requirements from the point of admission. For example, taking a detailed medicine history from the children's and young people guardian and undertaking medicine reconciliation on admission to hospital.
- The pharmacy team checked prescription charts for any missed doses with particular emphasis on omitted antibiotics or any high risk critical medicines.
- Audits on antibiotic prescribing were undertaken in line with national and local guidelines and discussed at the drugs and therapeutics committee. Specific areas were discussed at the drugs and therapeutic committee and quality improvement half days with nursing and medical staff. Discussion included raising awareness of correct prescribing with junior doctors.
- Pharmacy staff provided a regular medicine stock top up service. Staff we spoke with were positive about the service and told us it was very rare to run out of any medicines. We saw medicines for patients to take away upon discharge were individually dispensed and personally delivered to the DSU by the hospital pharmacy staff. Measures were in place to arrange for emergency supplies when the pharmacy was closed, such as restricted access by designated members of staff to an emergency medicines stock cupboard at the Birmingham Midland Eye Centre and to the main hospital pharmacy.
- Controlled drugs (CDs) are medicines which require additional security. CDs were stored in locked cupboards with restricted access which were bolted to the wall. We saw stocks of CDs were checked by two appropriately qualified members of staff at each shift change, and documented in the controlled drugs register. At the time of our inspection all stock levels were correct.
- An accountable officer for CDs had responsibility for ensuring safe storage and recording of CD. They undertook quarterly audits of CD medicine records and storage and shared the reports with the medicine safety committee and the local intelligence network. Any issues identified were highlighted and investigated with learning from incidents shared across the trust.

Records

- During our inspection we reviewed 11 sets of children and young people patient notes. In all of the records we looked at we saw evidence that all stages of the care pathway were documented and filed, and were legible and signed. The stages included pre-admission assessment, pre-operative assessment and safety checklists, anaesthetic and operation record, recovery notes, post-operative care and discharge plan and summary.
- We saw care plans were focused on the needs of children and their families, and included
- Individual care records were managed in a way that kept people safe. The hospital had a clear policy which described how records should be completed and stored. There was clear guidance on how information should be recorded and which areas of the records had to be filled in, for example, hospital numbers and discharge details.
- As part of the clinical audit programme senior nurses reviewed a random sample of 40 patient case notes each month. This showed an average of 73% compliance with records standards in the reporting period. Areas for improvement were discussed at staff meetings and reviewed on an ongoing basis as part of the monthly audit.
- Birmingham Midland Eye Centre was working towards a paper-light clinical environment in line with the trust's strategy. To support this move, the trust had invested in an electronic patient record system. At the time of our inspection children and young people's notes could be recorded on two different electronic systems, as well as paper records. This meant there was not always a unified patient record between different services within the hospital and that access to notes could be time consuming and confusing for staff. We saw evidence that two children and young people had their operations postponed in the last six months due to the unavailability of their records.
- Staff told us there were plans were in place for case note scanning to replace medical records from April 2017 It was anticipated that the changes would be fully implemented by July 2017.
- An electronic flagging system was used to identify children with safeguarding concerns. This was checked against the national Child Protection Information System to ensure that children subject to a child protection plan were highlighted when accessing services

Safeguarding

Services for children and young people

- No safeguarding concerns were raised at the time of our inspection, in the six months prior to our inspection and in the period from January 2016 until February 2017.
- The trust had an up to date children and young people's safeguarding policy. Staff we spoke with knew where to locate it. We saw dedicated noticeboards in all departments we visited displayed information about safeguarding children and young people, which could be viewed by staff and members of the public. These boards contained contact details for the safeguarding teams, where to find them and the service they provided.
- Staff we spoke to knew who the nursing safeguarding leads for the trust were, and could explain the actions they would take if they had any concerns.
- The safeguarding team would provide support to staff upon request and were available 24 hours a day, seven days per week. There were Safeguarding posters on display throughout the service.
- An electronic flagging system was used to identify children with safeguarding concerns. This was checked against the national Child Protection Information System to ensure that children subject to a child protection plan were highlighted when accessing services.
- The trust target of 100% for completion of safeguarding training for adults and children at level one and level two was met, and has been reported in the surgical, outpatient and emergency department core service reports. The trust safeguarding team were all up to date with safeguarding level 3 training for children and young people. This complied with Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document, 2014.

Mandatory training

- There were no separate arrangements for mandatory training for the children and young people service, as the service was delivered predominantly within the adult based services of the ophthalmology service within the surgical directorate at Birmingham Midland Eye Centre. This meant the trust were unable to report separately on mandatory training for the children and young people's service. This has therefore been reported in more detail in the surgery, emergency department and outpatients and imaging core service reports.
- We asked the trust to provide us with training records to show the extent to which staff at the Birmingham Midland Eye Centre had completed paediatric life support training. In response, the trust provided data about basic life support training, and told us they were unable to isolate the training data for paediatric life support. The completion rate for basic life support training for adults was 145 out of 136 staff which resulted in 61% compliance. This was well below the trust target of 95%. The lowest compliance rate was for medical staff at 45%. Orthoptists showed the highest compliance rate of 86% (18 out of 21 staff). Compliance amongst nurses and midwives was : 63% in the inpatient area (19 out of 30 staff) , 75% in outpatients (21 out of 28 staff), Operating theatre staff showed a compliance rate of 63% (19 out of 30 staff), and 72% (13 out of 18 nurse in the Emergency department.
- Mandatory training for all staff was a mixture of face-to-face and on line learning. Mandatory training modules included equality and diversity, information governance, fire training, infection control and manual handling. Other training was role specific for example, paediatric life support.
- Staff were alerted individually when their training was due for renewal by an automatic email sent to them to remind them to book a session.
- The trust target for mandatory training was 95%. This target was set in October 2016, therefore the trust have until October 2017 to achieve this target. As of 7 March 2017 Birmingham Midland Eye Centre had achieved 93% and was on track to achieve its target.
- The lowest completion rates were :conflict resolution update 77%, Infection prevention and control 78 %, information governance refresher 67%, medicines management69%, and resuscitation (basic life support) 61%.
- We asked to see the training records to see the breakdown of figures for each level of paediatric life support training for staff; however staff told us no records were available. We also requested this information from the trust, who told us that the training data for life support training, was reported as 'basic life support' with no distinction between adult and paediatric life support or any indication that life support training was provided at an intermediate or advanced level. We looked at records which confirmed this. However, minutes of the hospital care of the critically ill children's committee in January 2017 confirmed that all

children's trained nurses in the trust were up to date with European Paediatric Life Support Training (EPLS), Advanced Paediatric Life Support (APLS), or Paediatric Immediate Life Support (PILS).

- It was reported that 145 out of 236 staff (61%) had completed the basic life support training which was below the trust target of 95%. Assessing and responding to patient risk
- Guidance on the provision of paediatric anaesthesia services published by the Royal College of Anaesthetists states a paediatric early warning tool should be used post operatively to monitor the child's condition and detect early signs of deterioration. In all of the records we looked at we saw the use of nationally recommended age specific paediatric early warning systems (PEWS) were completed and that appropriate action was taken as a result of the findings.
- The World Health Organisation's (WHO) 'five steps to safer surgery' checklist was used to prevent avoidable mistakes. All records we reviewed contained completed safer surgery checklists with the risk outcomes documented. We observed staff completed the required safety checks: sign in, time in and sign out. However, the service did not collect audit data for the WHO 'five steps to safer surgery'.
- The patient was positively identified and procedure details confirmed against the consent form. Patients were also checked for allergies.
- If a child deteriorated to the extent they needed overnight or critical care they would be transferred to the main Birmingham City Hospital site. Safety huddles took place in each clinical department at least daily. Safety huddles are short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical, opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care. We observed this took place in the operating theatre.
- Staff were concerned that for emergency paediatric patients when no elective paediatric cases were due, staff on duty were not necessarily trained in paediatric life support, for example at weekends. Therefore, should an unexpected paediatric case be seen and the patient deteriorate; staff may not be trained to deal with this immediately and have to wait for the relevant response team to arrive from the main City Hospital.

Nursing staffing

- Nursing staffing was managed as part of the ophthalmology service. Nurses staffing in DSU was managed as part of the surgery inpatient area, emergency department, operating theatre and outpatients department and has therefore been reported in greater detail in the surgery, emergency department, operating theatre and outpatients and imaging department reports.
- The Royal College of Nursing Defining Standards for children and young people's services, 2014, states where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24 hour period.
- Two children's trained nurses, to a maximum of five patients, provided nursing care on the DSU. On the day of our inspection there was one patient and one nurse, supported by the matron and other children's trained nurse to cover for breaks. We looked at duty rotas for the previous four months and saw there were no variations in planned and actual staffing levels. This meant the RCN standards were adhered to. Staffing was reviewed informally on a daily basis with no acuity tool used.
- There were no children's trained nurses or operating department practitioners working in the operating theatre or outpatients department. However there was access to the children's nurses in the DCU and a paediatric anaesthetist would be in attendance. Children's nurses worked in the outpatients department on a sessional basis as part of the pre-operative assessment process. All staff could contact the two children's trained nurses, nursing lead, or paediatric ophthalmologist and paediatric anaesthetist for advice if necessary.
- The Birmingham Midland Eye Centre matron was also a children's' trained nurse and was available face to face or by telephone in core hours. The matron had responsibility and accountability for managing the team, providing budgetary control and a general overview of service provision.
- In addition, there was 24 hour access to senior children's nurses based in the paediatric assessment unit at the main City Hospital site. We saw evidence that there was a designated bleep holder for each shift with the authority to direct referrals to appropriate clinical areas and manage bed occupancy.
- Handovers took place in the staff rooms within patient areas to discuss any confidential issues such as safeguarding or other confidential issues.

Services for children and young people

- Where agency nursing and operating department practitioner staff were used we saw that comprehensive orientation and induction checklists were completed. There were no children's play specialist employed in the service as.

Medical staffing

- Medical staffing for children and young people was managed as part of the ophthalmology service and has therefore also been reported in greater detail in the surgery, outpatients and imaging and emergency department core service reports.
- Royal College of Paediatrics and Child Health guidelines state there should be a consultant paediatrician available in the hospital during times of peak activity, seven days a week. The day to day management of children rested with the consultant ophthalmologist on site for each shift. There was one children's trained ophthalmologist; who worked five days per week when BMEC was open. There was a daily on call rota, which included out of hours, for consultant ophthalmologists, not paediatricians.
- There were no agreed plans to increase the number of paediatricians.
- There were no formal arrangements in place to cover any anticipated or unanticipated absence of the paediatric ophthalmologist. Managers told us that instead, covering for such absences relied on an 'informal rota' of five ophthalmology consultants based on a goodwill arrangement, or the use of locum staff, and the extended role of orthoptists.

Major incident awareness and training

- There were no separate arrangements for major incident awareness and training and business continuity plans for the children and young people service, as the service was delivered within Birmingham Midland Eye Centre and the main City Hospital site. This has therefore been inspected and reported elsewhere in other core services in this report.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement because:

- There was limited engagement by staff to monitor and improve quality outcomes in the children and young people service. This was raised by the leadership team with us. However; since the appointment of the new consultant paediatric ophthalmologist in January 2017 work had commenced to undertake more specific monitoring of the children and young people service starting with a review of the emergency pathway for children. This was in progress and not yet reported upon at the time of our inspection.
- Staff and managers told us there was no agreed framework in place for staff without a children's qualification to develop and demonstrate competencies to care for children.
- Implementation of evidence based practice was variable. For example, senior staff told us care pathways for children requiring management of eye infections or emergency treatment were not clearly defined or developed. However they were able to demonstrate this was work in progress as part of a review by the consultant.
- Outcomes of care and treatment were not always monitored regularly or robustly. Participation in external audits and benchmarking was limited.

However:

- Consent practices and records were in line with relevant guidance and legislation.
- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE), Royal College of Anaesthetists, Royal College of Paediatrics and Child Health and Royal College of Nursing guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them.
- A comprehensive audit programme had been established by the orthoptists providing services to children and young people. The audit plan was based on audits required nationally as well as to assess compliance with local standards and policies.
- Staff used a pain scoring system with validated tools appropriate to developmental age and managed pain effectively.
- Multi-disciplinary teams worked collaboratively within Birmingham Midlands Eye Centre.

Evidence-based care and treatment

- Care pathways for children requiring management of eye infections or emergency treatment at Birmingham Midland Eye Centre were not documented. Medical staff told us they were therefore not clearly defined. The consultant was carrying out a review of services at the time of our inspection; therefore we were unable to assess the full impact of this.
- Policies and guidelines had been developed in line with national guidance. These included the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. A structured audit programme was run by the orthoptic team. The audit plan was devised to assess compliance with evidence based care as well as local priority audits identified through complaints and incidents.

Pain relief

- The Association of Paediatric Anaesthetists of Great Britain and Ireland's Good Practice in Postoperative and Procedural Pain, 2nd Edition 2012 says children and young people's care plans should include an appropriate pain assessment and management plan, and that a pain scoring system using validated tools appropriate to developmental age should be used. All of the records we looked at showed these were used and that pain was managed accordingly.
- We observed that following surgery pain was assessed on at least an hourly basis as part of clinical observations, using a formal patient reported scoring system. Children were asked to score their pain using an age-appropriate 'smiley face' assessment tool.
- We saw pain relieving medicines were prescribed for all children and young people in case they required them, and they were given with good effect and in a timely manner. Anaesthetists, ophthalmologists and nursing staff worked together to ensure pain was assessed and treated with good effect.

Nutrition and hydration

- Staff told us any specific dietary needs or allergies were checked and recorded as part of the child's initial assessment. Records we looked at confirmed this.
- There was no specialist paediatric dietician service at Birmingham Midlands Eye Centre; however staff could access specialist advice from the dietetic team at the main hospital site. Staff we spoke with told us this was a very rare occurrence and could not recall an occasion in the previous year.
- Staff described the pre-operative fasting guidelines used for children. These complied with recommendations of the Royal College of Anaesthetists. Information on fasting prior to surgery was provided as part of the pre-assessment consultation for children and young people having surgery.
- Nausea and vomiting were assessed and recorded in children and young people's notes. Anti-sickness medicines were available and were prescribed with good effect as required.
- Children and their parents told us they knew when they could and should not eat and drink both pre and post-operatively.
- Children and parents had access to hot drinks and snacks at all times if required as these were prepared by the catering staff. All staff were aware of when children were required to fast prior to surgery as this was identified at their bed space, in patient records and in instructions issued to catering staff. A small cafeteria was located adjacent to the DSU.

Patient outcomes

- We asked for evidence of outcomes in relation to children and young people. The leadership team told us that there had been no formal review of the service in the previous year or before that, and that it was currently a priority for the newly appointed consultant. Work remained in progress and so we were unable to fully assess the impact.
- The children and young people service was monitored as part of the ophthalmology service; therefore patient outcomes were inspected and are reported in more detail in the surgery service.
- A review of the Birmingham Midlands Eye Centre emergency department had begun which included an internal audit of children and young people attendance in the emergency department, in order to create a better understanding of who was accessing the services. This had not been completed or reported upon at the time of our inspection.
- However, the service had been part of an external quality review by the West Midlands Quality Review Service in October 2015 which had not identified any significant concerns.

Services for children and young people

Competent staff

- All staff working in the children and young people service were employed as part of the ophthalmology service; further detail is reported in the surgery service.
- The children's nurses and doctor had nationally recognised qualifications in both children's and ophthalmology specialist courses.
- Guidance on the provision of paediatric anaesthesia services published by the Royal College of Anaesthetists states in the period immediately after anaesthesia the child should be managed in a recovery ward on a one to one basis by designated staff with up to date paediatric competencies particularly resuscitation.
- We asked to see the paediatric competency framework and were told there was none in place. However, staff had access to the opinion of the children's nurses at Birmingham Midlands Eye Centre and a consultant paediatrician at the paediatric assessment unit at the Birmingham City Hospital main site at all times. Both were available for telephone advice for acute problems for all specialities. This met national and local requirements.
- In an emergency, operating theatre staff would call the resuscitation team from the main hospital site which they said could take about seven to ten minutes to arrive. In the meantime medical, nursing and operating staff at the Birmingham Midlands Eye Centre would provide immediate life support.
- Staff in the operating theatre told us they had difficulty in accessing training for paediatric life support training. One member of staff who looked after children and young people told us they did not meet the mandatory training requirements, had not completed any paediatric competencies, and there were no plans in place for them to do so. They told us that it had been particularly hard to access training since October 2016 due to staff shortages. We raised this with senior management at the time of our inspection. The leadership team within the trust told us that In previous months there had been high staff sickness within theatre and they have had to rearrange working patterns to cover lists ensuring patient safety. This has had an effect on some training. The trust reported that sickness levels were now less of an issue and there were plans in place to address the training. In particular it was anticipated that all staff will be compliant in completing paediatric life support training by mid-June 2017.
- We also asked to see the training records to assess the extent of the difficulties. Staff told us this data was not available.
- Agency staff with the required competencies were used to support operating theatre staff to ensure at least one member of the team was trained in paediatric life support for each shift. During our inspection we saw this worked well in practice?.
- Royal College Anaesthetist guidance, 2016, states that anaesthesia for children should be undertaken or supervised by anaesthetists who have undergone appropriate training.
- During core hours when scheduled operating lists were in progress we were told an anaesthetist trained in advanced paediatric life support was on site and would be summoned when required. However, we saw recorded on the risk register that there was no guarantee that staff trained to this level would be available out of hours, for emergency cases, or for times when elective surgery was not taking place, that the operating department staff had paediatric life support training, or that there would be a paediatric anaesthetist available.

Multidisciplinary working

- There was access to multi-disciplinary teams (MDTs) within Birmingham Midland Eye Centre. In particular, doctors and nurses worked closely with registered orthoptists who assessed diagnosed and treated children and young people with conditions such as squints, lazy eye, reduced vision, double vision and related eye problems, and the eye clinic liaison officer. There was no play specialist as patients were day care or outpatients.
- Where children and young people required mental health services, arrangements were in place enabling a referral to be made by the consultant to the Child and Adolescent Mental Health Service (CAMHS) via the patient's GP. Staff told us that such a referral had not been necessary from January 2016 until the time of our inspection.

Seven-day services

- Birmingham Midlands Eye Centre did not offer a seven day children and young people service. The outpatient service and emergency department were open 8am until 5pm Monday to Friday. Scheduled surgery was confined to Mondays and Thursdays only. When the

service was closed children and young people attended the paediatric assessment unit at the City Hospital site which provided a full range of services for children and young people who required assessment and hospital stays for up to 24hours.
- The Birmingham Midland Eye Centre pharmacy was open Monday to Friday, 9am to 1pm and 2pm to 4.45pm. Patients could attend the pharmacy at the main city hospital out of hours. However, staff told us this was a rare occurrence.

Access to information

- Policies and standard operating procedures were available on the intranet for staff to access current care and management information. Staff also had access to the on-line British National Formulary to provide up to date information about the use of medicines. Staff showed us that these were easily accessible and that publication and review dates were displayed. We saw that paper copies of the children's needs assessment forms were sent to each child's parents or carers, GP, and any other agency involved in their care upon discharge.
- Details of the child's school, GP and health visitor were recorded in all of the patient records we reviewed as well as any specific instructions for the primary health care team. Care summaries were sent to the patient's GP upon discharge. to enable continuity of care. This meant that details of the child's attendance and outcome at Birmingham Midland Eye Centre could be shared with relevant staff in the community

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff described the process of children and young people giving consent in accordance with the trust policy. Consent for care and treatment was obtained from children and young people or an appropriate adult, where applicable. The principles of Gillick competence were applied. Gillick competence is an assessment process where any child under the age of 16 can give consent for treatment if they have reached a sufficient understanding and intelligence to be capable of making up their own mind.
- In all of the records we looked at we saw children and parents were involved in any decision to operate. Each party signed a separate part of the consent form to show their involvement in the consent process.
- We saw consent forms were checked by operating theatre department staff as part of the World Health Organisation surgical safety checks in the anaesthetic room and operating theatre prior to surgery.

Are services for children and young people caring?

Good

We rated caring as good because:

- Children and young people and their parents were positive about the compassionate care they received. We observed kind and respectful interactions throughout our inspection.
- Emotional and social needs of children and young people and those close to them were embedded in all of the care and care plans we saw.
- Children and young people were enabled to maintain health and care and independence whenever possible.
- Parental access was encouraged in patient areas including day surgery unit (DSU), and the anaesthetic and recovery areas of the operating theatre, enabling their involvement wherever practical. Staff provided support for parents and ensured they were accompanied when in the patient areas.

However:

- The service did not report separately on children and young people friends and family satisfaction.
- We saw people could overhear consultations with other patients due to the open plan layout of the emergency department.

Compassionate care

- Children and young people and parents we spoke with were all positive about the care and treatment they received.
- We saw that staff generally upheld privacy and dignity in all of their interactions with children, young people, and parents. However, in the emergency department and outpatients department we observed that people could overhear consultations with other patients due to the open plan layout.

- We saw in the DSU and in the anaesthetic and recovery areas of the operating theatre department that privacy was upheld. Staff worked with parents to enable their involvement wherever possible.
- In the DSU we saw many thank you cards expressing gratitude and compliments from previous patients and parents about the care provided. A parent of a 17 year old wrote: "The staff on the ward and in the eye theatre were so understanding and friendly and put her at her ease throughout. I was very impressed with how sensitively and professionally they handled her".

Understanding and involvement of patients and those close to them

- We saw parental involvement was encouraged in the DSU and in the anaesthetic and recovery areas of the operating theatre department. Staff worked with parents to enable their involvement wherever possible.
- We found staff interacted with children and young people and their parents in a calm and friendly manner. We heard them use language appropriate to their age and level of understanding, and allowed enough time to ask questions.
- We observed staff explain surgical procedures to children and their parents.
- A named nurse was allocated to each child or young person on DSU, and they and. their parents knew which nurse was looking after them.
- Pre-assessment consultations provided the opportunity for information to be given to children and young people and their parents about planned procedures. It also offered the chance for children and young people and parents to visit the environment where they would be cared for.

Emotional support

- Staff enabled the broader emotional wellbeing of children and young people and those close to them by encouraging parents to be involved in care as much as they were able to.
- We observed a young child being given a general anaesthetic prior to surgery. All staff involved provided reassurance to the child and to the parent accompanying them to the anaesthetic room. The parent was then accompanied back to the DSU by the nurse for additional support whilst the child underwent surgery, and after surgery they were taken to the recovery area in the operating theatre, an also back to DSU.
- An eye clinic liaison officer (ECLO) was available either face to face in the outpatients' department or by telephone. We saw the ECLO listened to and supported children and young people and their families. The ECLO recommended relevant organisations and groups to provide support, interaction, and encourage independence particularly when children and their parents were dealing with sight loss.
- Emotional support could also be accessed in the multi faith chaplaincy service within the main hospital.

Are services for children and young people responsive?

Inadequate

We rated responsive as Inadequate because:

- Children and young people services were delivered in a predominantly adult environment. There were no separate adult and children and young people waiting areas, designated play areas, or children's toilets in the DSU, emergency department, or outpatients' department. Work was in progress to develop new facilities as part of the trust development programme
- The service was not operating at its optimum capacity as there was only one paediatric ophthalmologist in post, and elective (planned) surgery lists were contained to two sessions on a Monday and Thursday.
- There was no contingency arrangement for covering anticipated or unanticipated leave of the paediatric ophthalmologist, which meant an increased risk of cancelled surgery.

However:

- A recently introduced one stop pre-operative clinic helped to reduce trips to the hospital and potential loss of school time. If the nurses required any clarity, the consultant was available to answer any queries straight away, improving communication and confidence

- Extended role training was underway to manage a range of new and follow up patients in allied health professional (AHP) led clinics. This was designed to deal with the high volume speciality and to free medical staff to allow them to deal with more complex work.
- There were systems in place to raise concerns and complaints and evidence that learning took place in relation to issues identified.

Service planning and delivery to meet the needs of local people

- The service was provided in a children's day surgery unit (DSU) and predominantly adult based areas in outpatients, the operating theatre, and the emergency department.
- There were no separate waiting areas for adults and children and young people. designated play areas, or children's toilets in the DSU, emergency department, or outpatients' department. We saw adults and children waiting in the same area in the emergency department as there was insufficient waiting space for adults.
- Work was in progress to open new children and young people facilities as part of the service redesign programme development. However staff did not have access to the plans and were unclear what had been decided.
- The Royal College of Paediatrics and Child Health's 'Standards for Children and Young People in Emergency Care Settings' 2012 states children should be provided with waiting and treatment areas that are audio-visually separated from the potential stress caused by adult patients. The document also states children's areas should be monitored securely and zoned off, to protect children from harm, and access should be controlled. We were told there was a separate waiting area for children, and saw some toys were available. However, we saw adults and children waiting in the same area during our inspection as there was insufficient waiting space to separate adults and children.
- The consulting rooms in the Birmingham Midlands Eye Centre orthoptics department were large and two or three patients underwent consultations at the same time, only separated by screens. Patients were able to overhear conversations between staff and other patients in the room. Staff told us they were not able to protect patients' dignity and privacy due to the way the rooms were set up, but they had one single room they were able to use if patients or parents expressed concern. We asked if patients were told about this facility and offered it for their consultation, but staff said it was only used if patients raised the issue.

Access and flow

- From November 2015 to October 2016, 94 children and young people were admitted to the ophthalmology department for elective surgery and 13 patients underwent emergency surgery.
- The leadership team told us the service was not operating at its optimum capacity as there was only one paediatric ophthalmologist in post, and elective surgery lists were contained within two sessions on a Monday and Thursday.
- Children and young people undergoing emergency eye surgery were admitted to a children's ward within the main City Hospital, and transferred to and from the Birmingham Midlands Eye Centre operating theatre department.
- Between March 2015 and December 2016, data from the trust showed the number of cancelled elective operations was similar to the England average. From March 2015, the rates fell for two quarters before rising above the England average in September 2016.
- General surgery data showed that 91% of patients were seen within 18-week referral time. We asked for data specific to children and young people. This was not available.
- Consultant-led ward rounds took place twice daily to ensure effective and timely discharges and transfers of children within 23 hours.

Meeting people's individual needs

- Birmingham There was a specific children and young people DSU and children and young people post-operative recovery area.
- The appointment of the new paediatric ophthalmologist consultant in January 2017 had allowed for a 'one stop' service for children listed for surgery from the Monday children and young people outpatients' clinics. Children and their parents were escorted to the DSU where the children's nurses undertook their pre-operative assessment. This one stop service helped to reduce appointments and potential loss of school time. The children and young people and parents were provided with an

understanding of what should happen during surgery, who would be caring for them and the care environment. If the nurses required clarity, the consultant was available.
- Where English was not the first language spoken national interpreter services were accessible by telephone with a dual handset provided to support children and young people and their parents.
- We were told that carers of children and young people living with a learning disability were encouraged to attend consultations with the patient and remain with them during procedures where possible. Where children had a learning disability the service would liaise with community services including schools to ensure continuity of care.
- We saw that children were given an earlier time on surgical operation lists than adults. This meant that they were usually discharged within core hours when the paediatric ophthalmologist and paediatric anaesthetist were on site. It also reduced the time that they were fasting.

Learning from complaints and concerns

- The service encouraged feedback from children and young people and their parents using an age appropriate internal feedback form with smiley faces and a touch screen tablet. Complaints were managed by the surgical directorate and have therefore been reported in more detail in the surgery service report. There had been 14 complaints related to children and young people at Birmingham Midlands Eye Centre between January 2016 and December 2016, nine of which were upheld. Of the14 there were 10 complaints in the outpatients department, two in the orthoptics department and two in the emergency department. The main theme was waiting times.
- Staff told us that learning from complaints was shared at the monthly quality improvement half days. We looked at minutes from the three meetings in the previous six months and saw this was a standing agenda item.

Are services for children and young people well-led?

Requires improvement

We rated well-led as Requires Improvement because:

- The vision and values for the Children and young people service were not embedded at the time of our inspection. The leadership team told us that a specific strategy for children and young people's ophthalmology service was not in place as it was part of the wider ranging ophthalmology service.
- There was no separate strategy for the children and young people service or any succession planning for nursing staffing.
- Staff satisfaction was mixed. Staff told us they would like to see greater recognition and support of the children and young people service as they felt there was a lack of formal interaction with the trust executive leadership team.
- Staff told us the executive team were not visible at the Birmingham Midland Eye Centre and could not recall when they had last visited.

However:

- There were recently established systems in place to review the service in a more formalised way. This included a consultant-led review of emergency care for children and young people.
- Nursing leadership was seen to be visible and accessible and valued and respected by all staff we spoke with.
- Leadership within the orthoptist team was also described as supportive.
- Innovative practice in the orthoptic department included orthoptists extending their role to provide allied health profession led clinics for new and follow up patients. A more formalised system of monitoring and reviewing care had also been introduced.

Leadership of service

- Following a restructure at the trust, the ophthalmology service, including children and young people, became part of the surgical services directorate in December

2016. The directorate was led by a clinical director, lead nurse (matron), and general manager. The directorate reported to the surgical services group director, group director of nursing and group director of operations.

- At the time of our inspection, the clinical director was an ophthalmologist and the lead nurse was a children's trained nurse. Staff we spoke with felt that helped maintain the interests of the service. However, staff also told us they would like to see greater recognition and support of the children service as they described a historical lack of formal interaction with the executive leadership team. Whilst we acknowledge the executive team had took steps to visit the centre and speak with staff this was not the opinion of staff.
- Nursing leadership led by the matron was regarded as visible and accessible. We saw this to be the case throughout our inspection.
- Staff also spoke positively about the leadership within the orthoptist service. Managers were regarded as visible and accessible and staff told us they felt well supported.

Vision and strategy for this service

- The leadership team told us that the vision and values were trust wide. A separate strategy for children and young people ophthalmology service was not in place as it was part of the wider ranging ophthalmology service.
- The executive team showed us the trust wide vision 2016-2019 focused on: safety plan, patient experience, electronic patient records, and the development of a new hospital site. Staff we spoke with could not describe the trust vision or strategy, with the exception of telling us that the key focus was on the development of a new hospital site. However staff told us it was undecided at which hospital sites the children and ophthalmology service would be located as there were ongoing discussions about the availability of surgical equipment that would affect this. Staff understood no decision had been reached and did not feel involved in the decision making process. We heard that decisions about the recent closure of the ophthalmology ward and decisions about future service had been announced at board meetings without prior notice to staff including senior management.
- A review of the ophthalmic paediatric surgical services by the paediatric ophthalmologist had been commissioned by the Medical Director to assess the safety and efficacy of the future service. The review was in its early stages and therefore we were unable to assess its impact.

Governance, risk management and quality measurement

- Children and young people ophthalmology service operated within the surgical directorate.
- Managers held quarterly governance meetings, which fed into the surgical directorate governance meetings. We saw minutes of the meetings held in April, July and October 2016, and January 2017, which recorded discussions about clinical effectiveness, risk management, complaints, incidents, risks, and patient feedback. The minutes also detailed how the surgical directorate was performing on staff appraisals, mandatory training, and sickness. This has therefore been reported in greater detail in the surgery core service report.
- Staff we spoke with told us risks identified in the children and young people service were contained within the surgical risk register and identified the three main risks which aligned with what was documented. The highest rated risk was that children, particularly less than three years of age, who attend the emergency department at the Birmingham Midlands Eye Centre with an emergency eye condition, do not receive either timely or appropriate treatment due to limited availability of specialist medical staff. From August 2015 to July 2016, 858 children aged under three attended the emergency department. Although it was unclear when this was first reported as a risk staff told us this had been a long standing situation which remained unresolved. We were told that a consultant-led review of the service was in progress but not yet completed. There was no agreed completion date for any corrective action.
- Another main identified risk on the risk register was the inadequate facilities for children and young people in outpatients leading to a lack of privacy, dignity and confidentiality due to the design and layout of the outpatients department. We saw similar risks in the emergency department which had not been recorded on the risk register. Staff told us the facilities for children and young people would be prioritised as part of the new building design; however there was uncertainty about where the new service would be located.

- The third main risk on the register was theatre list cancellations within Birmingham Midlands Eye Centre due to staff shortages resulting from high rates of sickness and vacancies within the trained staff establishment. This was not specific to the children and young people service, as the ophthalmology service was predominantly for adults This has therefore been reported in more detail in the surgery core service report.
- The matron compiled monthly exception reports to identify early issues with specific indicators, including nursing staff indicators, management and leadership indicators and quality and safety indicators. Depending on the findings, local action was taken when appropriate or escalated to the senior management teams or group director. We saw the January 2017 report, which identified the indicator findings. There had been no formal complaints.

Culture within the service

- The children and young people service was part of the ophthalmology service; therefore this was inspected and reported in the surgery, outpatient and imaging and emergency department core service reports.
- A member of the leadership team told us: "I am very proud to work here, take referrals, and deal with challenging conditions".

Public engagement

- There was early work in progress with the trust communications team to include parents in a review of a parents' information folder. However, this had not yet been reported on so we were unable to assess its impact.
- We observed age specific feedback was sought from patients and parents on the day surgery unit using a personal computer. This was a new initiative which had not been reported on at the time of our inspection.

Staff engagement

- Staff we spoke with was positive about the use of the hospital intranet as a key means of communication with the executive leadership team and other colleagues, and considered such communication worked well on a daily basis. However, there was a mixed understanding of the longer term direction and proposed restructure of the children and young people service and staff told us they did not always get consulted before trust board discussions or receive feedback of the discussion outcomes. Managers told us the trust's senior management team regularly proposed changes to the ophthalmology service without consultation.
- Medical staff also told us that since the service had moved to the surgical directorate in December 2016 they felt there was more positive engagement with the executive team particularly with the consultants.
- Staff told us there had been improvements in the staff survey during 2016. However there was no separate report related to the children and young people service. Further detail is therefore reported in the surgery, emergency department and outpatient and imaging core service reports.

Innovation, improvement and sustainability

- A programme of monthly 'quality improvement half days' was introduced across the trust during 2016 with the aim of engaging all clinical staff in order to address areas that required improvement, promote discussion, encourage reflection and discuss how clinical delivery could be improved. Minutes of the meetings we looked at showed where staff from the service had discussed recent complaints, for example. Another session had included a presentation by the parent of a child with a learning disability who had been a service user at the Birmingham Midland Eye Centre for many years. The presentation highlighted the parental and patient perspectives of using the orthoptic and paediatric ophthalmology services. The aim was to raise staff awareness, engage staff in reflective practice and improve service delivery. Staff we spoke with told us the sessions were well attended and useful.
- Managers told us an orthoptist was currently undertaking extended role training to manage a range of new and follow up patients in allied health professional (AHP) -led clinics. This included management of children with: chalazion, blepharo kerato conjunctivitis, vernal conjunctivitis, allergic conjunctivitis, epiphora or naso lacrimal duct obstructions. This innovation was designed to deal with the high volume speciality and to free medical staff to allow them to deal with more complex work. The AHP-led clinic would commence once the required training was completed and had not yet been introduced.
- Improvements had been made to the environment within the children's electrophysiology room. It had

been repainted and age appropriate stickers and murals had been purchased to brighten up the room to try and lessen anxiety. It was described as more compatible with the international electrophysiology standards the service was required to follow. There were fixation pointers to encourage children to look at the television screen during testing.

End of life care

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

Information about the service

End of life care was delivered at City Hospital by a palliative and end of life care service based in the palliative care suite at Sandwell Hospital.

Sandwell and West Birmingham Hospitals NHS Trust provide an integrated palliative and end of life care service for anyone requiring it, in the population of 530,000 people in the West Birmingham and Sandwell area. The trust held the Sandwell and West Birmingham Hospital palliative care register on their electronic patient record system.

The trust provided a consultant led palliative and end of life care service managed by the palliative and end of life care nurse manager. End of life care was delivered across wards at City Hospital where patients with end of life care needs were identified The palliative and end of life care service is part of the Community and Therapies iCares directorate.

The service had a five-year strategy (2013 – 2018) that included the development of the integrated team that had been developed to identify further developments for the team.

The integrated end of life and palliative service included:

- A connected palliative care coordination hub which was a single point of access available seven days a week, 8am to 8pm.
- An urgent response team available seven days a week, 24 hours a day.
- Acute and community specialist palliative care nurses were available seven days a week with on call arrangements for evening and overnight.
- Palliative medicine consultants available five days a week with on call arrangements evening, overnight and at weekends.
- End of life care facilitators available seven days a week from 8am until 8pm.
- The Macmillan Occupational Therapist Team available seven days a week between 8am and 4pm.
- The Heart of Sandwell Day Hospice opened Monday to Friday and could accommodate up to 12 patients each day.

The service had a register of all patients who were identified to be in their last 12 months of life. Between 1 April 2016 and 31 March 2017, 1003 patients were placed on the end of life register. There were 511 deaths of patients on the end of life register who had a supportive care plan (SCP) in place.

The mortuary department was separate to the main City Hospital building and had capacity for 90 deceased patients.

City Hospital had an on-site chaplaincy service and a multi-faith chapel for people who wished to pray. There was also a certificate and bereavement team on the hospital site who arrange for the Medical Cause of Death Certificate to be released and also provide more practical support such as registering the death and contacting the funeral director.

End of life care

During the inspection, we met five patients, spoke with relatives, and reviewed 12 patient care records. We spoke with 22 staff delivering end of life care. This included the palliative and end of life care service, ward staff and accident and emergency staff. We also spoke to the certificate and bereavement team, porters and mortuary staff. We observed staff providing care to end of life care patients and their families.

In addition, we reviewed the trust's performance data about end of life care at City Hospital before, during and after the inspection.

Summary of findings

We have rated the end of life services at City Hospital as outstanding overall. We rated safe and caring as good and effective, responsive and well-led as outstanding.

This is because;

- Experienced staff provided a compassionate and responsive service for end of life care patients.
- The service provided access to care and treatment in both acute hospitals and in the community, seven days a week, 24 hours a day.
- The service followed evidenced based guidance incorporating National Institute for Health and Care Excellence (NICE) guidance including NICE QS13 End of Life Care for Adults (Nov 2001/updated Mar 2017) and The Five Priorities for Care of the Dying Person (Leadership Alliance 2015).
- Incidents for the palliative and end of life care service were low. Staff were knowledgeable about the trust's incident reporting process and we saw concerns were investigated and learning shared.
- The service had one single point of access for patients and health professionals to coordinate end of life care services for patients.
- The palliative and end of life care service was well developed across the trust and held in high regard by all of the wards we visited.
- End of life and palliative care was a priority for the trust. The service was well developed, staffed and managed as part of the iCares directorate within the Community and Therapies clinical group.
- There was a clear governance structure from ward and department level up to board level. Good governance was a high priority for the service and was monitored at regular governance meetings.
- Staff were proud of their service, and spoke highly about their roles and responsibilities, to provide high levels of care to end of life patients.
- We saw patient's care often exceeded patient's medical needs. We were told of numerous examples where the service had gone the extra mile. This included arranging a wedding on a ward so a person in their last few days of their life could marry their long term partner. Staff had decorated the ward to make the event as memorable as possible.

End of life care

- Advanced care plans and supportive care plans were used across the trust for end of life patients. Staff used them as a person centred individual care record to include all the needs and wishes of a patient and their family.
- A holistic assessment of the patient's needs regarding an individual plan of care had been carried out in the last 24 hours of life in 94% of cases compared to the national average of 66%.
- The trust used a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form. The trust DNACPR was easily identifiable with a red border and was stored at the front of the patient notes. We saw all DNACPR forms were completed accurately on the wards. This was a significant improvement since our last CQC inspection in October 2014 where we raised concerns about the completion of DNACPR forms.

However:

- There had been three injuries suffered by porters transporting patients to the mortuary in two separate incidents in May 2016 and November 2016.
- The trust's 'Anticipatory Medication Guidelines' was due for review in September 2016 but no updated guidance was available. We could not be assured staff were following the most up-to-date guidelines.
- Mandatory training for mortuary staff did not include infection control training.

Are end of life care services safe?

Good

We rated safe as good because:

- Between February 2016 and January 2017, the trust reported no incidents classified as never events for end of life care.
- Staff were knowledgeable about the incident reporting system and staff learned lessons from concerns.
- Staff working within the palliative and end of life care services had received up-to-date mandatory training.
- Staff could demonstrate they understood the duty of candour in relation to end of life care patients.
- Safeguarding end of life patients was a high priority for the palliative and end of life care service. The trust had developed strong links with external agencies to prevent patients being abused. Safeguarding training figures exceeded the trust training target of 85% for safeguarding both vulnerable adults and children (level 1 and level 2).
- Staff regularly assessed, monitored and managed risks to patients who used the service. A consultant and palliative care clinical nurse specialist were available to discuss patients and their treatment needs 24 hours a day, seven days a week.
- During the previous CQC inspection of SWBH in October 2014, it was noted that the floor in the mortuary where two examination tables had been removed was "rough, uneven and cracked in places." During this inspection, we saw the floor had since been repaired and could therefore be cleaned effectively by mortuary staff.

However:

- There had been three injuries suffered by porters transporting patients to the mortuary in two separate incidents in May 2016 and November 2016.
- Mandatory training for mortuary staff did not include infection control training.
- Palliative and end of life care service staff had not received major incident planning or training despite this being raised during the previous CQC inspection.

Incidents

- Between February 2016 and January 2017, the trust reported no incidents classified as never events for end

of life care. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

- Between February 2016 and January 2017, palliative and end of life care staff reported 71 incidents. There were 30 no harm incidents, 37 low harm and four moderate harm incidents reported. Incidents included: identified power, phone and information technology failures, which could lead to delays in patients contacting the service for advice (14 incidents). One incident was a medication error and another related to lack of availability of anticipatory pain relief for a patient.
- Porter staff told us of two incidents (May 2016 and Nov 2016) where brakes on a trolley had failed. We reviewed the incident forms for both of these incidents. Both of these incidents were reported to RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) as three of the porters had been off work for over seven days as a result of their injuries.
- As result of both of these incidents, porters sustained back, shoulder and neck injuries whilst moving patients to the mortuary. Porters were advised to use alternative patient trolleys which were not suitable for this purpose. Porters told us trolleys were an ongoing problem which they had raised with the trust but had not been addressed.
- All staff we spoke with knew how to report incidents via the trust's electronic reporting system. The palliative and end of life care service lead told us they reviewed all incidents to identify any themes and trends regarding concerns.
- The palliative and end of life care team manager and team leaders we spoke with during the inspection told us and we saw in meeting records between February 2016 and January 2017, staff discussed incidents during staff meetings and handovers. We saw staff took an electronic record during the weekly end of life multidisciplinary meeting to ensure this information was shared with all staff, including those who were not on duty. This ensured staff learned lessons from these incidents.
- Minutes from the end of life Steering Group Meeting for November 2016 and January 2017 showed senior staff discussed incidents during these meetings.
- Duty of candour is a regulatory duty that is related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person. There had been no end of life care incidents which required duty of candour (DoC) investigation in the palliative and end of life care service.
- We asked eight staff about their DoC responsibilities. All were aware the term meant being open, honest and transparent with patients in their care. Mortuary staff were able to give us an example of an incident where duty of candour may apply. Mortuary staff told us if this happened they would inform their manager who would contact the family.
- Palliative and end of life care service staff told us they would raise incidents when working on specific wards, such as medication errors. Staff told us they received feedback from managers about incidents they had raised. This included the outcome and learning points fed back to staff via email. Staff told us this was a good learning opportunity and useful to identify if staff needed further training.

Cleanliness, infection control and hygiene

- The trust's infection prevention and control policy was up-to-date. We noted it was due for review in April 2017. Staff could easily show us policies relevant to their area of working. These were easily accessible to staff on the trust's intranet.
- We reviewed training records and found that all staff from the palliative care team had completed their mandatory training on infection prevention control.
- Porters we spoke with knew the personal protective equipment (PPE) requirements for the mortuary and knew how to access the necessary equipment. Porters and mortuary staff told us and we saw the PPE store was well stocked and equipment was in date.
- Mortuary staff and porters told us about the procedures they followed and equipment they used when transporting and moving deceased patients. This assured us staff could recognise, assess and manage any associated risks. For example, when moving deceased bariatric patients, mortuary staff would ask for assistance from the porters to safely move the patient.
- Ward staff we spoke with knew the procedures for conducting 'last offices' to minimise infection risks, such as wearing PPE if a patient had a suspected or

confirmed contagious disease. The 'last offices' refer to the care given to a patient shortly after death. Staff should treat the patient's body with respect, and take into consideration the wishes expressed by the patient before her or his death, and the wishes of the family following death.

- We visited the mortuary department and viewing area and saw they were clean, tidy and well ventilated.
- During the previous CQC inspection of SWBH in October 2014, it was noted that the floor in the mortuary where two examination tables had been removed was: "rough, uneven and cracked in places." During this inspection, we saw the floor had since been repaired and could therefore be cleaned effectively by mortuary staff.
- There were sufficient handwashing facilities and clinical waste and general bins on ward areas and in the mortuary.
- Mortuary technicians were responsible for cleaning all 'dirty' areas of the mortuary such as fridges and trays. Hospital domestic staff cleaned 'clean' areas such as the changing rooms and waiting room. We saw up-to-date weekly cleaning schedules for each area mortuary staff were responsible for cleaning for February 2017 and March 2017. This showed mortuary staff had completed regular cleaning within the required timescale. Mortuary staff told us they disinfected the hoists each week and the cleaning records we reviewed confirmed this.
- Infection Prevention and Control Audit and Surveillance reports for September 2016 to January 2017 showed the mortuary department did not conduct hand hygiene audits. Therefore, we were not assured the service was protecting mortuary staff and the general public that visited the mortuary.
- We saw one member of the mortuary staff who did not adhere to the trust's infection prevention and control policy as they did not have 'arms bare below the elbow'. This staff member wore numerous bracelets on both arms. This could pose potential health and infection risks to this member of staff as jewellery could become contaminated with bodily fluids or infections from contact with deceased patients. In addition, this could be transferred to visitors to the mortuary via cross contamination. We raised this concern with senior management after the inspection. When requested, this member of staff easily accessed this policy on the trust's intranet.
- We saw a mortuary technician followed the mortuary general cleaning standard operating procedure (SOP) when releasing a patient to an undertaker by cleaning a fridge tray with disinfectant wipes before returning the tray to the fridge.

Environment and equipment

- Staff told us and we saw suitable equipment was available to meet end of life patients' needs such as syringe drivers and pressure relieving equipment. We saw staff used and maintained syringe drivers in line with professional guidance.
- We saw the mortuary was equipped with two hoists to lift deceased patients into the top fridges. The servicing of these hoists was within date and we found they were visibly clean. We saw records for the preceding three months to confirm the hoists were disinfected each week.
- The mortuary could accommodate 90 deceased patients in total. This included capacity for 52 patients in the refrigerated main mortuary area and 38 in the temporary storage room. This included four bariatric fridges for larger deceased patients. The service was not using the side room to accommodate any deceased patients at the time of our inspection. However, staff told us the entire room could be temperature controlled when needed. Staff told us these facilities were suitable to meet the needs of City Hospital and the local area.
- Mortuary staff told us there were alarm systems in place monitoring the fridge temperatures. These would alert staff if the temperatures went out of the acceptable temperature range.
- The mortuary was clean and clutter free however, it was housed in an ageing building and there was evidence of damp on the walls.
- We checked the thermometers used to monitor the temperatures of the storage fridges in the mortuary. They were within the required range and we saw records confirming staff had conducted daily temperature checks on Monday to Friday when staff worked at the mortuary.
- An alarm system was in place to alert staff if fridge temperatures went above the recommended settings within the mortuary. A central alarms computer at the switchboard monitored fridge temperatures out-of-hours. If the system detected any faults, the

switchboard operator would contact the on-call mortuary technician. Staff told us there had been no recent incidents where the alarm system had been activated.

- There was a certificate and bereavement team on the hospital site who arranged for the Medical Cause of Death Certificate to be released. The team also provided more practical support to relatives such as registering the death and contacting the funeral director. Certificate and bereavement staff told us their manager had arranged for security measures to be put in place at their office such as a coded lock door and a panic button was installed. This was in response to staff raising concerns about potential aggressive behaviour of recently bereaved relatives.
- Porters told us it could be difficult transporting patients to the mortuary on trolleys as one of the paths leading to the mortuary was uneven and the lighting on the path to the mortuary was insufficient at night. Staff told us and we saw cars were also parked next to this path which made it difficult to manoeuvre the trolleys.
- Some concealment trolleys had been taken out of service, as they were deemed unsafe. Porters told us they were using a bariatric trolley and trolleys from accident and emergency instead. Porters told us the bariatric trolley was too wide to fit into some of the hospital areas such as the acute medical unit.

Medicines

- We reviewed six end of life patient records where anticipatory medication had been correctly prescribed in accordance with national guidelines. Anticipatory medicines are a small supply of medications for patients to keep at home so they are available when patients need them. A doctor or nurse can only administer anticipatory medicines. They are an important part of end of life care as they help control symptoms end of life patients often experience such as pain, nausea, agitation and chest secretions.
- We saw extensive discussions took place regarding medicines for symptom management for patients in addition to discussions with other staff such as dieticians, occupational therapists and psychologists.
- We saw ward based medical and nursing staff worked closely with pharmacy staff to ensure end of life patients received medication in a timely way so they could be discharged quickly for rapid home to die discharge.
- We saw a resource folder available on an acute medical unit containing extensive information about symptom management.
- Staff told us when patients were discharged home they were given 28 days' supply of medication.
- We reviewed the storage of controlled drugs on wards and found they were securely stored and in date. Electronic keys were used for the medication cupboards and we saw records for controlled drugs were maintained and securely stored in line with trust policy.
- The palliative and end of life service had seven medical prescribers within the team. We saw nurses who were qualified to prescribe medicines for symptom management reduced the delay in patients receiving medicines to ease suffering.
- The hospital had syringe drivers to deliver medication to manage symptoms for end of life patients needing continuous pain relief. Syringe drivers allow medication to be delivered at a regular rate over a 24-hour period.
- We visited the medical device library where staff told us and equipment library records showed there were 26 syringe drivers currently unaccounted for. Staff had logged out most of these to patients discharged home or into nursing homes. Medical device staff told us they had flagged this issue to their managers. The service was considering implementing a specific returns pack for postage back of syringe drivers to the library following patient discharge. For the remaining 80 syringe drivers in the trust, the storage and maintenance system for syringe drivers was robust. Medical devices staff visited wards to collect all syringe drivers no longer in use from designated points Monday to Friday.
- Nursing staff told us they could access syringe drivers out-of-hours from the medical device storage area as porters had keypad access and would deliver them to the ward.

Records

- We reviewed 12 sets of patient records. We saw they contained relevant information, were accurate, complete, legible, up-to-date and stored securely. Staff wrote and managed patient's individual care records in a way that kept patients safe. We saw the involvement of the palliative and end of life care service was extensive in relation to end of life care patients and was well documented in their notes. We saw patient records were updated daily with regular patient review by the palliative and end of life care service.

End of life care

- The palliative and end of life care service used the supportive care plan (SCP) when caring for end of life patients in their last year of life. Staff used the SCP to ensure appropriate symptom multidisciplinary assessments were conducted.
- We reviewed the care records of a patient and saw medical and surgical staff had documented all necessary information. We saw from the patient notes, ward staff had referred this patient to the palliative and end of life care service for review and assessment. Staff supported the care provided to the patient with a SCP.
- End of life patients also had an advanced care plan (ACP). This allowed staff to support patients to have access to individualised care tailored to the patient's needs.
- We saw the SCP and ACP were held in a patient's records. Staff had completed the SCPs and ACPs fully; they were legible and were signed and dated appropriately. The SCP contained the palliative and end of life care service coordination hub contact details, care plans, risk assessment details, anticipatory drug prescribed and the patient's individual preferences regarding their death.
- We saw in depth discussions took place between staff and relatives regarding the ceiling of care. The ceiling of care or treatment is put into place to improve the management of acute episodes of deterioration for patients with an end of life diagnosis. It provides information as well as appropriate limitations to interventions or treatments which are likely to be ineffective and difficult for the patient at end of life. For example not to transfer end of life care patients to ITU. Staff should discuss these decisions with the patient wherever possible and those important to the patient (as highlighted in the 5 priorities for the Care of the Dying Person).
- We saw mortuary staff recorded details of deceased patients in the mortuary register. Information included names, jewellery, fridge numbers and if the patient had any infections. Staff also documented details of the deceased's jewellery in a property book.
- We saw there was a process in place in the mortuary when two deceased patients had the same name. We saw this in practice where staff put an asterix next to the name on the front of the fridge door, to draw attention to the similarities and allowing staff to take extra precautions. The trust did not have a specific same name policy.
- The End of Life Care Audit, 2016 found at the time of death, 94% of end of life patients had a DNACPR decision in place. Documented evidence that a discussion regarding CPR was undertaken by a senior doctor with the patient was recorded for 35% (3230/9302) of people. When sudden and unexpected deaths are removed, this equates to 36% (2748/7707). The reasons documented for the lack of discussion were appropriate, but for 16% (961/6072) there was no reason recorded. In the 2013 audit, a discussion about CPR was carried out with 21% of the overall sample and 41% of the patients who were capable of participating in such discussions.

Safeguarding

- At the time of the inspection, 100% of staff had completed safeguarding adults level 1 and 85% of staff had completed safeguarding adults level 2 training. In addition, 100% of staff had completed safeguarding children level 1 training and 92% of staff had completed safeguarding children level 2 training. These training figures exceeded the trust training target of 85% for safeguarding both vulnerable adults and children (level 1 and level 2).
- Staff we spoke with knew who to contact if they had any safeguarding concerns. They told us the safeguarding lead was easily accessible if they required further advice. They understood their responsibilities to safeguard vulnerable adults and children from abuse in line with safeguarding standards and the trust's policy.
- The trust had safeguarding children and safeguarding adult's policies in place. Staff showed us they could easily access these via the intranet. Both policies included information about types of abuse, a flow chart for staff to follow when reporting abuse in addition to useful contact details such as Sandwell Children's Social Services Team (MASH) and the trust's safeguarding team.
- We reviewed the trust's policy for the safeguarding and protection of vulnerable adults' policy which staff relied upon and found it had been due for review in August 2016 but had not been updated. We escalated this to the senior management team following the inspection, as this is a trust wide senior management responsibility.
- We observed in the multidisciplinary team meeting (MDT) staff discussed safeguarding concerns regarding end of life patients and senior staff made appropriate arrangements.

End of life care

Mandatory training

- The trust's integrated palliative and end of life care service provided treatment and support to end of life patients in the community and in both acute hospitals. Data provided by the trust showed as of March 2017, 93% of the palliative and end of life care service of staff had completed all required mandatory training against the trust target of 95%. Mandatory training in the service was overseen by the palliative and end of life care service lead. Subjects for this mandatory training included medicines management, resuscitation: basic life support, Safeguarding Adults Level 1 and 2 and Safeguarding Children Level.
- Mandatory training for mortuary staff consisted of moving and handling – patient handling, Safeguarding Adults Level 1 and Safeguarding Children Level 1. As of March 2017, 100% of mortuary staff for both acute sites had completed all of their mandatory training against the trust target of 95%.
- We saw infection control training was not part of mortuary staff's mandatory training and therefore staff may not be aware of precautions to take to protect themselves and the public from potential infection.
- At the time of our inspection, end of life care training was not mandatory for porters and mortuary staff who also came into contact with end of life patients whether it was before or after death.

Assessing and responding to patient risk

- The palliative and end of life care service had sufficient cover to ensure appropriate staff were available should a patient deteriorate. The service provided a face-to-face service across both acute sites between the hours of 8am to 8pm, seven days a week. The team also provided telephone on-call cover outside of these hours from 8pm until 8am across City Hospital and Sandwell General Hospital. Staff provided advice, support to patients, relatives, and staff where required. A senior nurse prioritised all calls received at the hub dependent on patient need and individual risk of the patient. Palliative and end of life care service staff told us and information received from the trust showed urgent cases were seen within 30 minutes of referral to the team.
- Staff told us and we saw the service prioritised care and treatment for patients with the most urgent needs by triaging patients daily according to need. Patients who were dying and in need of daily symptomatic review and or family support were seen by palliative and end of life care staff each day. Those patients who were more stable and were comfortable and settled were seen less frequently. The ward staff could contact the palliative and end of life care service to request additional support if the need arose.
- Staff handovers we observed were effective at identifying and managing patient risk.
- Regular review of end of life patients by the palliative and end of life care service identified if patients had increased needs. For example, if patients needed regular mouth care or a change to medication (such as a syringe driver), palliative and end of life service staff ensured these needs were met.
- The introduction of the Supportive and Palliative Care Indicators Tool (SPICT) helped staff to identify patients requiring palliative care and end of life service. The SPICT was a guide for staff to identify patients at risk of deteriorating and dying. The tool looked at general indicators of deteriorating health and clinical indicators of one or more advanced conditions. We saw a hard copy of this tool was available on the wards and was also easily accessible on the trust's intranet. Patient records we reviewed showed regular assessments of patients' needs to minimise risks and maximise symptom control. Staff used the supportive and palliative care indicator tool as assessment.
- The SCP included risk assessments of patients' nutrition, mobility, and skin integrity.

All care records we checked showed these risk assessments had been regularly

reviewed.

- The palliative care team anticipated the patients who may deteriorate over the weekend and put measures in place to ensure staff closely monitored the condition of these patients.

Nursing staffing

- We saw there were sufficient and appropriately trained palliative and end of life care staff to meet the needs of end of life patients at City Hospital.
- The end of life service was led by a palliative care service lead supported by one band 5 project facilitator (1 whole time equivalent (WTE)).

End of life care

- Within the connected palliative care hub there were five acute clinical nurse specialists (CNS) (4.6 WTE), one lead band 7 end of life facilitator, five band 6 WTE end of life care facilitators with one WTE vacant post, two band four care coordinators (1.28 WTE) and five band two administrators. Staff took calls at the hub between 8am and 9pm, seven days a week.
- The urgent response team had one senior sister WTE (band 7) team lead, nine WTE junior sisters (band 6) palliative care nurses and one occupational therapist. Staff told us there was usually at least two staff on duty. The service operated 24 hours a day.
- The Macmillan therapy team had three band 6 staff (2.8 WTE) with one rotational band 5 staff member (1 WTE) and one band 4 therapy assistant (0.85 WTE). Occupational therapists and occupational support workers in the team supported end of life patients.
- The hospital had sufficient CNS staff. However, a member of the nursing staff told us: "even palliative and end of life care service staff are always stretched. We do extra hours and stay over our hours which we don't get paid for."
- The palliative and end of life care service used regular agency staff to fill staffing gaps. Staff told us two members of staff were currently off sick long term.
- In order to fill any gaps in the service and respond to capacity requirements the palliative and end of life care service had started a rotation between acute and community specialist palliative care nurses. We saw that this had allowed staff to work in either acute or community settings when required in response to patient need.

Medical staffing

- The Sandwell and West Birmingham Trust (SWBH) palliative and end of life care service consisted of 1.6 whole time equivalent (WTE) palliative medicine consultants. The consultants provided care, treatment and advice for all end of life patients within Sandwell and West Birmingham Hospital Trust. This included both hospitals and the community.
- The Association for Palliative Medicine of Great Britain and Ireland and the National Council for Palliative Care guidance states there should be a minimum of one WTE consultant per 250 beds. The trust had 764 beds (460 beds at City Hospital and 304 beds at Sandwell hospital). This equates to in excess of three WTE consultants. Despite the trust falling well below this recommendation, we saw this did not have a negative impact on patient care at the trust. The palliative and end of life service was large and well supported by administrative staff and we saw this offset this deficit in consultant hours.

Other staffing

- The trust employed four full-time mortuary technicians covering both City and Sandwell Hospital sites. Mortuary staff worked at both acute sites and covered the City Hospital mortuary one week in every four weeks. Staff told us the rota system ensured there were sufficient staff on each site to meet the demands of the mortuary service.
- Porters transported deceased patients from the hospital wards to the mortuary. They had out-of-hours access to the mortuary and porters were trained to book deceased patients into the mortuary facility.
- The trust employed five full time chaplains and three part time faith leaders who provided chaplaincy support across both acute sites. The chaplaincy service provided an on-call service and staff; patients and relatives could access chaplains from a number of different faiths 24 hours a day, seven days a week. The chaplaincy service included Roman Catholic, Hindu, Sikh and Muslim faith leaders.

Major incident awareness and training

- We saw the trust had a major incident plan in place. Palliative and end of life care service staff and mortuary staff we spoke with were aware of the plan and could access it on the trust's intranet.
- Data received from the trust showed the palliative and end of life care service staff had not received major incident planning or training. In the event of a major incident, the mortuary staff would be required to respond appropriately to that. This had been raised during the previous CQC inspection. However, staff we spoke to knew where to access information and policies on major incidents if they needed.
- Mortuary staff told us they could use a side room where the whole room could be temperature controlled in the event of a major incident.
- Mortuary staff told us in the event of a power cut there was an emergency generator in place.

Are end of life care services effective?

End of life care

Outstanding ☆

We rated effective as outstanding because:

- We saw the palliative and end of life care service cared for patients in accordance with their individual needs and staff delivered care in line with current evidence-based guidance, standards, best practice and legislation.
- A holistic assessment of the patient's needs regarding an individual plan of care had been carried out in the last 24 hours of life in 94% of cases compared to the national average of 66%.
- We saw a significant improvement in the completion of DNACPR since our last CQC inspection in October 2014 where we raised concerns about incorrect or incomplete information on DNACPR forms.
- We saw the service had systems and procedures in place to effectively monitor and manage end of life patients' pain relief needs.
- Staff met end of life patient's diet and fluid needs by referring patients to the trust's dietician if necessary and we saw examples of this documented in some patient notes.
- The service monitored patient outcomes through national and local audits. These were reported to the board via the palliative care and end of life dashboard and trust's quality report.
- Multidisciplinary (MDT) working was effective in the palliative and end of life care service as one integrated team worked across the trust in both the acute and community ensured timely access to end of life professionals.

However:

- The trust did not have updated 'Anticipatory Medication Guidelines'. This meant we could not be assured staff were following the most up-to-date guidelines.
- The palliative and end of life care service did not conduct audits of pain relief and were not using national guidance.

Evidence-based care and treatment

- We saw the palliative and end of life care service provided end of life care and patients had their individual needs assessed and their care planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Palliative and end of life care services was delivered in accordance with best practice as per NICE guidance CG140, QS13 and 5 Priorities for Care. We saw the palliative and end of life care services achieved the priorities for Care of the Dying Person as set out by the Leadership Alliance for the Care of Dying People.
- Staff followed the trust's own policies and procedures when caring for end of life patients.
- Relevant information, policies and procedures needed to deliver effective care and treatment to end of life care patients were easily accessible to staff on the trust's intranet.
- We reviewed the trust's 'Anticipatory Medication Guidelines'. This was due for review in September 2016 but no updated guidance was available. This meant we could not be assured staff were following the most up-to-date guidelines. Ward staff told us they could obtain further support from the pharmacy team if required.
- The trust used a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form which was easily identifiable with a red border and was stored at the front of the patient notes. We saw all DNACPR forms we reviewed were completed accurately on the wards in line with national guidance published by the General Medical Council. This was a significant improvement since our last CQC inspection in October 2014 where we raised concerns about incorrect or incomplete information on DNACPR forms. All of the DNACPR forms we reviewed showed detailed best interest discussions had taken place with the patient's family in all cases and had been signed by consultant. This had been well documented in the patient notes by medical consultants and the palliative and end of life care service staff.
- Since the removal of the "Liverpool Care Pathway" (LCP) nationally, the trust had developed a personalised end of life care pathway called the supportive care plan (SCP). We saw the trust used the SCP throughout the hospital with an advanced care plan available for those patients within the last 12 months of life.
- The Advance care plan (ACP) is a nationally recognised means of improving care for people nearing the end of life. The plan enabled improved planning and provision of care and to support people to live and die in the place and manner of their choosing.

End of life care

Pain relief

- Systems and procedures were in place to monitor and manage pain relief needs of end of life patients.
- We saw patients had access to both traditional medicines or alternative therapies such as reiki, massage, reflexology and Indian head massage to help manage their pain.
- Staff told us they did not audit pain control for the palliative and end of life service. However, staff told us they audited the supportive care plan which included an assessment of all symptoms.
- Patients identified as needing end of life care were prescribed anticipatory medicines which included pain relief. Anticipatory medicines are a small supply of medications for patients to keep at home so they were available when patients need them. Only a doctor or nurse can administer them.
- We reviewed six prescription charts of end of life care patients. They all had the required information and evidenced medication was administered and prescribed in line with national guidance.
- The trust told us and we saw they had a separate pain management service that followed policies based on NICE and Royal College guidelines. The service did not use the 'Faculty of pain medicines' core standards for pain management (2015) guidelines specifically for palliative and end of life care.
- We saw ward staff discussed pain relief and pain management plans with patients and their relatives. Relatives we spoke with told us staff managed their relative's pain well.

Nutrition and hydration

- Staff ensured they met end of life patient's diet and fluid needs by referring patients to the trust's dietician if necessary and we saw examples of this documented in some patient notes.
- Nutritional assessments had been completed in the patient notes we reviewed and this formed part of the SCP. This helped staff to ensure a patient's dietary intake was sufficient.
- We saw in patient notes speech and language therapists had conducted swallowing assessments for end of life patients.
- A SWBH NHS Trust leaflet: 'The Last Days of Life' gave relatives and carers information about patients in the last days of their life requiring less food and drink.
- City Hospital scored 94% in the Patient-Led Assessments of the Care Environment (PLACE) 2016. This was better than the average score large acute trusts achieved at of 89%.
- We observed staff discussed potential problems end of life patients may experience with eating and drinking at a weekly multidisciplinary team meeting and gave advice regarding options available to assist patients.

Patient outcomes

- The trust used an advanced care plan (ACP) that identified patient's choices and preferences for palliative and end of life care for those patients within their last 12 months of life. Advance care planning is a nationally recognised means of improving care for people nearing the end of life to enable better planning and provision of care, to help patients live and die in the place of their choice in the manner of their choosing.
- We reviewed twelve sets of patient records and saw use of the Supportive Care Plan (SCP) for patients on wards. The SCP detailed actions for staff to follow once active interventions were considered inappropriate and emphasised comfort and quality of life for patients. These included, stopping unnecessary tests, observations, anticipatory medication guidelines and documenting the patient's preferred place of care. The SCP included risk assessments of patients' nutrition, mobility, and skin integrity. All care records we checked showed these risk assessments had been regularly reviewed.
- We saw patient records on the wards included the patients' preferred place of care (PPC) and place of death (PPD). Preferred place of death (PPD) was recorded on the trust's electronic patient system.
- The service monitored patient outcomes through both national and local audits. These were reported to the board via the palliative care and end of life dashboard and trust's quality report.
- The trust retrospectively audited records of patients who had died to review the care and treatment they had received. The audit was conducted between 1 January 2017 and 31 March 2017(information was collected and shared monthly with information for March 2017 provided by the trust following the inspection). This identified: 78% of patients had an advanced care plan, 76% of patients achieved their preferred place of care (trust target 70%), and 72% of patients achieved preferred place of death (trust target 70%).

End of life care

- The trust took part in the 'End of Life Care Audit - Dying in Hospital, March 2016. The audit showed of the key symptoms that could be present around the time of death, within this trust: controlled patients' pain in 85% of cases (national average: 79%), agitation/delirium in 69% of cases, (national average: 72%), breathing difficulties in 75% of cases (national average:68%), noisy breathing in 71% of cases (national average: 62%) and nausea or vomiting in 46% of cases (national average: 55%).The trust achieved six of the eight organisational key performance indicators (KPIs) which included having one or more end of life care facilitators as of 1st May 2015.
- The trust were not able to demonstrate they had a lay member on the trust board with a responsibility for end of life care.
- The trust performed better than the England average for all five of the clinical indicators from the audit as the trust could demonstrate within the last episode of care: it was recognised the patient would probably die in the coming hours or days in 98% of cases (national average: 83%), health professionals recognised the patient would probably die in the coming hours or days, and imminent death had been discussed with a nominated person(s) important to the patient in 93% of cases (national average: 79%).
- The End of Life Care Audit identified a holistic assessment of the patient's needs regarding an individual plan of care had been carried out in the last 24 hours of life in 94% of cases (national average: 66%).
- The service carried out an audit of why end of life patients preferred place of death (PPD) was not achieved between 1 April 2016 and 31 October 2016. The results showed: PPD was achieved in 64% of cases and a significant proportion of deaths did not have a record of PPD at 24%. Where patients did not achieve their PPD, the service examined this in detail to explore the reasons and help inform practice to improve future outcomes. For example, social issues accounted for the highest proportion of failure to achieve PPD at 30%. Included in this category were cases where care packages could not be arranged in a timely manner and those that were in place but where family carers deemed the social support to be insufficient. The majority of cases with social issues died outside of acute hospitals and utilised home from home beds and nursing homes.
- The audit identified a number of recommendations to improve PPD outcomes such as end of life care facilitators to target wards and areas where there were delayed discharges.
- The trust did not take part in the Gold Standards Framework Accreditation for Acute Hospitals scheme. Senior staff in the palliative and end of life care service made this decision based upon review work undertaken by the trust with their clinical commissioning group.
- We saw the palliative and end of life care service audit programme included audits such as: 'Percentage of appropriate patients for whom the Supportive & Palliative Care Indicators Tool (SPICT) tool is applied and an advanced care plan is made' (April 2016 – March 2017) and an 'Audit of Macmillan therapy team supervision' was due to commence in April 2017. We saw the service monitored the palliative and end of life care service to improve patient outcomes and used the information from audits to make improvements to the service.

Competent staff

- We saw from data provided by the trust 71% of palliative and end of life service staff held a palliative care qualification which would assist staff in providing a high level of care to end of life patients. The lead nurse of the service had an MSc in advanced practice – palliative care, 27 staff were trained in advanced communication skills and 20 staff held the European certificate in essential palliative care. We found eight staff were non-medical prescribers and were therefore qualified to help manage end of life patients' symptoms, such as prescribing strong pain relief to ease symptoms.
- The trust had 106 McKinley T34 syringe drivers in use, shared across both acute

sites. Training records showed palliative and end of life care service staff had to

conduct syringe driver training and pass an assessed competency.

- We saw a list of all courses the palliative and end of life service staff had attended. For example, five staff had attended the three day palliative care conference, four staff had conducted the sage and thyme communications course and one nurse had completed a reflexology course. Members of staff at a UK university developed the 'SAGE & THYME' model and foundation

level workshop. The aim was to teach the core skills of dealing with people in distress. By attending conferences and relevant training courses, the service were keen to keep updated with any advances related to end of life care in order to provide individualised care to end of life patients.

- The palliative and end of life care service were responsible for providing end of life care training for general ward staff outside of the specialist team. We saw examples of educational presentations such as: on 'Care after death', 'Comfort care at end of life', 'Communication', 'Diagnosing dying', Spiritual Care at End of Life', Supportive Care Plan, 'Symptom Control'.
- The palliative and end of life care team delivered End of life care (EoLC) to ward staff in several ways so they had the necessary skills to deliver EoLC to patients on their wards. This ranged from palliative and end of life care study days the palliative and end of life care service delivered and EoLC facilitators also gave EoLC training to ward staff. Ward staff were then able to return to their own areas and share their knowledge regarding EoLC with their colleagues. The palliative and end of life service and the EoLC facilitators also gave staff one to one informal learning when they attended on wards to assess and review new or follow up patients.
- The palliative and end of life care service had developed an eight week end of life care training programme for staff at SWBH trust. This included for example, training on using the supportive care plan, comfort care, symptom control, communication and spiritual care.
- The palliative and end of life care service provided numerous end of life care related training courses to all staff outside of the palliative and end of life care service throughout the year. This included: clinical support for health-care professionals, lunch and learn for health-care assistants (4 times per year), end of life care for community nurses (sessions throughout the year), palliative care for community therapists (sessions throughout the year), and principals of palliative care for all qualified staff (8 sessions) for example.
  Non-specialists were also encouraged to participate in advanced communication skills training.
- Formal in-house training specifically covered communication skills training for care in the last hours or days of life for nursing (non-registered) staff.
- The palliative medicine consultants also provide tailored education for GP trainees from Sandwell and West Birmingham as part of their training programme.
- We saw the trust had an end of life training plan. Staff confirmed they were able to easily access end of life related courses. These courses were identified during their appraisal and their managers supported them to attend courses as necessary.
- End of life care facilitators attended palliative care meetings at GP practices to support staff and provide teaching to nursing and care home staff. End of life care was provided by non-specialists across the trust. Patients at the end of life can be transferred into dedicated home from home beds in our Leasowes centre where staff provided care supported by the palliative care team.
- We saw the palliative and end of life care service recently held a two-day training event at City Hospital covering 'end of life and palliative care competencies'. Staff told us all professionals were invited to this training in addition to community care home staff.
- Data we received from the trust showed all newly appointed staff completed a corporate and local induction as soon as possible after joining the trust and ideally within their first six weeks (non-medical staff) or two months (medical staff). Staff completed mandatory training and any key competencies specific to their role.
- Porters received training from mortuary staff and shadowed other porters to gain information about how to respectfully move patients.
- Data received from the trust showed as of February 2017, 95% of palliative and end of life care service staff had completed their appraisals. This was against a trust target of 95%.
- A systematic approach to education of all staff and communities to raise awareness of services available and to improve early recognition of dying patients and promote advance care planning.
- The trust had held quality improvement events since April 2015. These were protected learning time and non-essential clinical services were stopped for four hours, one afternoon every month. Staff were encouraged to take part.

Multidisciplinary working

- Multidisciplinary (MDT) working was effective in the palliative and end of life care service. Staff told us and we saw that one integrated team with the connected palliative care coordination hub that worked across the trust in both the acute and community ensured timely access to end of life professionals. Staff from different

teams and services were involved in assessing, planning and delivering end of life patient's care and treatment. Staff discussed new patients, complex patients and patient deaths from the preceding week at these meetings.

- Staff delivered care in a co-ordinated way when different teams or services were involved. The connected palliative care coordination hub had established strong links with other providers of end of life care in the Sandwell and West Birmingham area. This included local hospices and charitable organisations. The service aimed to improve the care provided to end of life patients when they moved between different care providers.
- We saw speech and language staff had involvement with an end of life patient on wards to conduct swallowing assessments.
- Chaplain staff told us they felt part of the end of life team. The chaplaincy lead attended monthly meetings with departmental managers to understand what each department had to deal with.
- The palliative and end of life care service staff visited wards at both acute hospital sites and also attended palliative care meetings at GPs.
- Staff told us and we observed they discussed recently deceased patients in detail at MDTs to share learning of what went well and what may be improved on.
- The Macmillan therapy team was based in the acute office at both acute sites in the hospital therapy team. We saw evidence of good multidisciplinary (MDT) working with the palliative and end of life care service.
- MDTs were held at the connected palliative care coordination hub at Sandwell Hospital each week where staff discussed patient outcomes. We saw there was effective communication between the palliative and end of life care service to ensure patients received care delivered in a coordinated way.
- The palliative and end of life care service used an electronic Palliative Care Co-Ordination System (EPaCCs). Staff used this to share patient's electronic records about their care and treatment electronically, securely and privately. This system ensured that information about a patient could be shared (with the patient's consent), amongst health care professionals involved in the patient's care, including ward staff, palliative care nurses, medical staff, community nurses and GPs (GPs who had the EPaCCs system).
- Staff also discussed the transfer of patient care from a hospital setting to the community during weekly MDT meetings. We saw there was a clear process for the transfer of care from City Hospital to community services. Patient referrals to the hub included a need for specialist palliative care advice, referral to the urgent response team, the home from home or hospice bed, Macmillan therapy team or referral to the Heart of England Hospice. As the palliative and end of life care service was one team both acute and community services were integrated across both hospitals and in the community.
- Community patients admitted into hospital were highlighted by the end of life facilitators so they could be reviewed and their progress and discharge to the community monitored. When patients were discharged the hub would alert the palliative care nurse specialists so they could continue to review their care when they returned home. We observed that the palliative and end of life team ensured continuity of care when patients were discharged from hospital to community care or into a home from home bed including access to care plans and provision of medication.
- Palliative and end of life care service senior staff told us they attend cancer site specific meetings and nutrition MDTs to discuss tube feeding for patients for example. Staff told us they also attended weekly ward rounds and haematology rounds.
- Staff told us and we saw all details of patients with a supportive care plan were added onto the hospital electronic bed management system to ensure members of the MDT were aware of their enhanced needs.
- Staff from all areas of City Hospital that were involved in end of life care told us they had a good working relationship with the palliative and end of life care service and could access them easily if required.
- Certificate and bereavement service staff told us they have a good relationship with mortuary staff as they communicate on a regular basis.
- Mortuary staff knew how to provide feedback to porters for example regarding booking in deceased patients out-of- hours.

Seven-day services

- The palliative and end of life care service provided a seven day face-to-face access to specialist palliative care. The team was available from 8am – 8pm. Calls received by staff at the hub between 8pm and 8am were

transferred to the out-of-hours doctor's service. Calls relating to end of life care were forwarded to the end of life facilitators and the trust's urgent response team. There was a clinical nurse specialist available seven days a week within the hospital and then on call during evening and weekends alongside a consultant in palliative care. This ensured experienced palliative care staff were available to provide advice to other professionals when required.

- There was always someone in the hospital who was competent to commence a syringe driver. The mortuary operated a 24 hour service to provide mortuary cover for all hospital wards and departments. Out-of-hours the on-call mortuary staff could be contacted if relatives wanted to view relatives for example. Mortuary staff requested that relatives made appointments for viewing relatives but told us sometimes families would arrive unannounced.
- The chaplaincy team were available 24 hours a day, seven days a week. Outside of their normal working hours chaplaincy staff were available on-call. We were given examples of when the chaplain team had visited patients and relatives at request out-of-hours.
- The certificate and bereavement office (CARES) was open from Monday to Friday from 9am - 4pm.
- Ward staff we spoke with were aware of how to contact the palliative and end of life care service out-of-hours to get in touch with a clinical nurse practitioner.
- The palliative and end of life care service worked seven days a week to support advance care planning and discharge planning with support from discharge co-ordinators.
- The palliative care hub was open seven days a week to provide advice to professionals supporting rapid discharge by arranging admissions to home from home and hospice beds. The hub could also arrange respite and night sits to support people discharged.

Access to information

- The connected palliative care coordination hub ensured information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- There was a trust wide end of life register providing an up-to-date list of all patients staff identified to be in their last 12 months of life receiving end of life care at the trust. The register held information about end of life patient's treatment and preferences to ensure they received timely and individualised care.
- All staff could easily access the trust's policies and procedures on the trust's intranet.
- Palliative care consultants told us they were able to access the patient record register from home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 12 sets of patient records and all showed there had been discussions with patients who had the capacity to understand DNACPR. Mental capacity assessments were clearly recorded to support the DNACPR decisions.
- We reviewed 14 DNACPR forms; an appropriately senior clinician had signed all.
- The End of Life Care Audit 2016 identified that a DNARCPR order was in place for 94% of patients' notes at the time of death.
- Best interest discussions with patients and those important to them were excellent because they were clearly and concisely documented in patient's notes. We saw staff had recorded in medical records who was involved in the discussions. It was evident what was said and to whom it was said and who said it. It was also clear that those involved the best interests discussions were given the time to digest the information and to come back and further discuss if questions arose.
- The DNACPRs we reviewed showed discussions had taken place between patients and their relatives were recorded.
- We saw staff placed yellow stickers on patient notes to indicate Deprivation of Liberty Safeguards had been considered.
- We observed staff obtained consent from patients before treating them. Staff also obtained and documented consent from patients to add them onto the supportive care plan and end of life register.
- We saw palliative and end of life care service staff understood consent regarding the Mental Capacity Act (MCA): Code of Practice, 2005 and Deprivation of Liberty Safeguards.
- Mental Capacity Act, 2005 training was included as part of the trust's adult safeguarding training.

End of life care

Are end of life care services caring?

Good

We rated caring as good because:

- Staff were passionate about their service and we saw numerous examples of staff going the extra mile to meet patients medical and wellbeing needs to provide person centred care.
- We saw staff cared for patients in a compassionate, supportive and dignified way.
- We saw staff valued patient's emotional and social needs and these were embedded in their care and treatment.
- Relatives said staff kept them fully informed and they were involved in decisions about care.
- We saw appropriate communication and discussions took place between ward staff and families of end of life patients.
- We saw mortuary staff handled deceased patients in a sensitive and professional way. Mortuary staff told us if there were any concerns about the condition of deceased patients received at the mortuary, there were processes in place to feed back to ward staff and porters to address issues.

Compassionate care

- We saw and families confirmed staff cared for patients in a kind, compassionate, dignified and respectful manner. Staff were highly motivated and inspired to offer kind and compassionate care.
- One palliative nurse told us they would "personally go the extra mile" for their patients.
- Staff spoke to patients politely and respected their privacy and dignity by asking patients for their consent before carrying out any personal care. Staff drew curtains and used side rooms when available to provide as much privacy and dignity as possible for both the patient and family and friends visiting.
- Certificate and bereavement office staff told us their manager had given them training in how to communicate with bereaved relatives when they joined the trust. Staff told us they had spoken to recently bereaved parents whose baby had died and they had spoken to them in a sympathetic and understanding way.
- Certificate and bereavement staff told us they: "wanted to get things done for the family to make it easier for families, especially for women who had lost babies."
- We saw families were given the opportunity to carry out their own last offices for their relative.
- Staff told us there was no pressure from bed managers to remove deceased patients from the wards. This ensured there was sufficient time for relatives to see their relative and perform last offices if they wished without being rushed.
- Porters told us they maintained the dignity of the deceased by ensuring the curtains were closed when collecting them from the wards.
- We saw staff spoke to patients in a kind and sensitive manner and asked for their consent before providing more intimate procedures.
- Relatives told us staff respected patient's privacy and dignity when they provided care. Porter staff said they dealt with the deceased in a compassionate and respectful way.
- We observed mortuary staff moved patients in respectful manner.
- Accident and emergency staff told us they put up dignity signs if a patient had died.
- On one of the wards, staff told us they had arranged a wedding for an end of life patient at short notice as their condition had deteriorated over a weekend. The chaplaincy team and palliative care team arranged for this ceremony to take place. The side room was decorated. The partner told chaplain staff: "Staff on the ward were amazing." Chaplaincy staff told us: "it was such a beautiful service which was sacred and sanctifying for the couple." The chaplaincy staff visited this end of life patient each day following the ceremony up until the patient's death.
- Staff contacted the trust's chaplain team and the patient's wishes were discussed with the patient. The marriage ceremony took place in a ward side room staff had decorated. A registrar performed the service on the following Monday which was attended by staff and the patient's close family. Staff told us details of the wedding were due to be published in the trust's heartbeat magazine.
- We saw from the End of Life Care Audit - Dying in Hospital, 2016 the trust performed better than the England average (84%) as 96% of the trusts patients had been given an opportunity to have concerns listened to.

End of life care

- We saw results from a patient experience questionnaire the palliative and end of life care service had conducted between September 2016 and February 2017. Patients, relatives, or friends with experience of end of life care at the trust completed this. There were numerous positive comments included in the results: "All staff have been helpful, professional and caring", "Everyone has been excellent, felt well supported and being able to keep mom at home was great", "felt input of service has been very good from CNS, benefits advisor and hub service. Telephone support service has been very reassuring", "Was able to address all concerns regarding equipment needs, pain relief advice and also they chased up information from oncologist", "We were very impressed with (staff name), she was amazing with my husband she was so caring, kind and considerate and made me and my family feel so much better about the sad situation we were in." Also (staff name) was amazing she was compassionate and took away a lot of pressure from us. We are very grateful". However, there was one negative comment: "No review of care as of yet, been eight weeks and now no discussion regarding treatment or investigation."
- We saw mortuary staff handled deceased patients in a sensitive and professional way. Mortuary staff told us if there were any concerns about the condition deceased patients were received at the mortuary, there were processes in place to feedback to ward staff and porters to address issues.
- Porters told us mortuary and ward staff treated deceased with dignity and respect.
- Family members told us palliative and end of life care service staff respected patient's privacy and dignity particularly when ward staff were giving intimate care. We observed on the wards care when staff were caring for patients it was done with privacy and dignity behind screens and curtains.
- Chaplaincy staff told us they provided support to patients when requested. The Chaplains conducted walk arounds to raise staff awareness about the chaplaincy service and also picked up work along the way. Chaplains told us they always go to the critical care unit: "I support staff who have been supporting patients especially on critical care wards."
- We saw the palliative and end of life care service sent bereavement cards to relatives of end of life patients who had passed away whilst on a specialist care plan.
- A member of the rapid response team stated the best part of the job was: helping people in times of need."

Understanding and involvement of patients and those close to them

- Staff, patients and relatives we spoke with told us staff communicated with patients in a caring and supportive manner so they understood their care, treatment and condition. We reviewed 12 sets of patient's notes, which documented discussions with patients, and relatives which showed patients and relatives were actively involved in their care and treatment. We saw staff consistently empowered patients to have a voice and staff demonstrated they understood the importance of involving people and those who matter to them in decisions about their care.
- Relatives and patients told us staff went the extra mile and patients felt really cared for.
- We saw excellent communication and discussions took place between ward staff and the family of an end of life patient who had a specialist care plan in place.
- We observed excellent communication skills of a palliative and end of life care service clinical nurse specialist (CNS) with an end of life patient and family when assessing the patient. Staff also discussed the patient's preferred place of care (PPC) with the patient and family.
- Formal in-house training specifically covered communication skills training for care in the last hours or days of life for medical and nursing staff.

Emotional support

- Palliative nurses and the chaplaincy team provided emotional support for end of life patients and their relatives. We observed excellent examples of ward staff providing relatives with emotional support. One example we saw was when relatives were given the opportunity and time to approach those staff caring for the patient and such support was given in a caring and compassionate manner. Relatives were taken to a private area if they wished to talk or had concerns with the consent of the patient if appropriate. Further support to contact the chaplaincy was offered but declined.
- The bereavement office also provided emotional and practical support to relatives following a bereavement.
- We saw in specialist team meeting minutes from September 2016, senior staff reminded staff all relatives

should be offered bereavement care support provided by a national charity for bereaved people the trust had strong links with. Senior staff reminded staff to make sure that next of kin details were correct so bereavement support could be offered to those who required it.

- Staff in the chaplaincy team could offer spiritual support to patients 24 hours a day, seven days a week. To cater for all a number of religious needs, the team had chaplains from Christian, Hindu, Muslim and Sikh faiths. Other faith leaders were also welcome to visit the hospital if patients or relatives requested. A member of staff told us: "chaplains could be easily contacted by phone. Each religious leader is very accessible and team working is great."
- Porters told us their managers were supportive. One porter told us how their manager offered them additional support when they had suffered a recent family loss. Their manager made appropriate arrangements for them to avoid transferring deceased patients after they had been recently bereaved.
- Porters told us they would be able to access counselling if they required it, for example after transferring a deceased baby or child.
- Accident and emergency staff told us the trust provided up to six free counselling sessions for staff to cope with difficult situations such as child deaths.
- Certificate and bereavement staff told us they do not have access to additional support regarding difficult situations they encounter in their role.
- We saw thank you cards addressed to the bereavement team in the certificate and bereavement office. Comments included positive comments about staff being: "exceptionally helpful."

Are end of life care services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- The palliative and end of life care services were tailored to meet the needs of individual patients using the service. We saw care was delivered in a way to ensure flexibility, choice and continuity of care for end of life care patients including those with urgent needs.
- The Connected Palliative Care Coordination hub ensured patients had timely access to treatment, support and care. The palliative and end of life care service worked together with commissioners and other providers to plan new ways of meeting people's needs. The service had a strong focus on innovative approaches of providing integrated care pathways, particularly for patients with complex or multiple needs.
- Patient admission, discharge and moving patients between hospital care and care in the community followed models of best practice in integrated, person-centred care.
- The palliative and end of life care service designed services to meet the needs of the local community to enable all people to access palliative and end of life care services.
- Patients had seamless access to care, support and advice 24 hours a day seven days a week.
- Access to care, support and advice was managed and timely to take into account patient's needs, including those with urgent needs.
- The service had strong links with external providers and charities to provide the best possible individualised care to patients.
- Staff told us end of life care facilitators were extremely flexible. They would visit end of life patients on wards and assess patients to determine if they should be on SCP when required.
- Between October 2016 and December 2016, 100% of patients at the trust on an end of life care pathway were seen within 24 hours of referral to the palliative and end of life care team.
- Between 1 April 2016 and 31 March 2017, the palliative and end of life care service had not received any complaints.

Service planning and delivery to meet the needs of local people

- We saw patient's individual needs and preferences were central to the delivery of palliative and end of life care.
- In 2015, the trust, with clinical leadership from the palliative and end of life care service won the £3.6 million per year, five year contract to be the main provider of all specialist palliative and end of life care services for patients registered with the Sandwell and West Birmingham CCG, with a population of around 500,000 people.
- The service had innovative approaches to providing integrated person-centred pathways of care that involved other service providers. For example, the

Connected Palliative Care partnership was created to deliver the new contract with private and voluntary organisations. It specialised in end of life and palliative care to provide holistic services for patients in the last 12 months of life. The partnership included the following services: a specialist palliative team, Macmillan therapy team, connected palliative care coordination hub, urgent response team, 'Home from Home' beds, specialist hospice beds and a day hospice.

- The programme to deliver the contract included the recruitment of new staff including: a team of end of life care facilitators to provide education and advice to non-specialist teams in order to improve end of life care to enable the service to provide advice and when required support 24 hours a day seven days a week.
- In addition, the service ensured continuity of care as we saw the service the connected palliative care single point of access coordination hub was set up to take all calls and enquiries and managed a Sandwell and West Birmingham CCG end of life care register. The service ensured there was increased availability of end of life care beds with 24 hours a day seven days a week access.
- Staff arranged for occupational therapy and physiotherapy assessments to be carried out.
- Staff told us they no longer carried out post-mortems at the City Hospital mortuary. Mortuary staff at the Sandwell Hospital site conducted post-mortems if required.

Meeting people's individual needs

- The service had a proactive approach to understanding the needs and preferences of patients approaching the ends of their lives.
- We saw staff discussed the supportive care plan with the family of an end of life patient. Family members were given a second opinion at their request about the feeding method used for a relative.
- We saw a review of a patient with dementia whose diagnosis was very detailed. The service had a 'this is me' booklet for patients with dementia. This was used to support communication between dementia patients and staff. The booklet was given to close relatives to complete to document the patient's likes and dislikes and include patient history.
- The hospital ensured patients requiring palliative care support were identified in a timely way and that deceased patients were cared for in a culturally sensitive and dignified way. This adhered to the 'National Institute of Health and Care Excellence '(NICE) QS13: end of life care for adults (2011).
- The certificate and bereavement service staff told us if families requested a rapid release for deceased relatives, the patient could be released on the day they passed away. All paperwork was completed on the ward, including the death certificate.
- We saw the mortuary department had a dedicated baby concealment trolley.
- Staff could arrange reduced parking fees for patients and relatives receiving end of life care. This was to help relatives spend as much time as possible with their relative as possible.
- The hospital had a certificate and bereavement department services (CARES) team to provide information, advice and support to bereaved families. The service provided practical information following the loss of a loved one.
- The hospital produced leaflets available for patients, friends and relatives to offer practical support and advice. These included 'help for the bereaved: a practical guide' and 'the last days of life.'
- The chaplains visited patients when staff, patients or relatives requested their support. The chaplaincy team worked across both acute hospital sites. We saw a rota for March 2017, which showed which chaplain was on duty. There were five chaplains covering a number of different faiths: Roman Catholic, Muslim, Sikh and Hindu. During the week from 9am to 5pm there was a duty chaplain covering both acute sites. A duty chaplain covered out-of-hours from 5pm to 9am.
- A team of 15 volunteers supported the chaplaincy team six days a week across both acute sites to support end of life patients.
- Ward staff told us and we saw they tried to provide side rooms for patients receiving end of life care. This was to give a quieter and more private environment for the patient, their family and friends.
- A multi-faith chapel was available to all patients, relatives and hospital staff. It contained information about a number of faiths including Christianity, Islam, Hinduism and Sikhism.
- The mortuary provided safe accommodation for adults, children and babies who had died at City Hospital.

End of life care

- There was a viewing area available next to the mortuary for families and friends to view their deceased family or friend. The mortuary viewing area was well maintained and sensitively decorated. There was a separate waiting area with comfortable chairs all in good order.
- Staff told us they could access translators easily either face-to face or over the phone for patients whose first language was not English.
- Staff told us and we saw on a number of wards caring for some end of life patients, there were end of life care information leaflets available to relatives in a number of different languages.
- Staff told us they were able to get a package of care in place over a bank holiday weekend to allow an end of life patient to be discharged home. We were told the hard work of the nursing team ensured this was made possible. Staff had discussions with the patient and relatives about logistics of enabling patient discharge. Ward nurses, the medical team and pharmacy staff ensured anticipatory end of life medicines were prescribed and ready in time for discharge. The palliative and end of life care service in the community arranged equipment. Transport was also arranged. The urgent response team also provided personal care and staff gave us examples of how they had cared for patients who had deteriorated over weekends when no other services were available.
- The timeframe for urgent and non-urgent referrals was based on the West Midlands specialist palliative care guidelines and followed national NICE guidance. Timeframes were as follows:
  - For urgent specialist palliative care: review was within one working day.
  - For non-urgent specialist palliative care review was within five or 10 working days (option for either on the referral form and a decision was made by the referrer.)
  - Referral for the urgent response team: the review was within 30 minutes.
- The urgent response team had seen 686 patients at hospital and 1105 at home between October 2016 and March 2017.
- Ward staff gave us another example of arranging the discharge of a patient whose preferred place of care and death was at home. Ward staff made arrangements for this patient to be discharged as soon as possible. The staff achieved the discharge on the same day. This patient passed away in his own bed as he had wished several hours after arriving home. His family were extremely grateful staff had arranged this.
- Staff arranged for an end of life patient to be re-housed so they would be closer to friends and family. Staff supported end of life care patients to access benefits and food banks as necessary.
- Staff and relatives of end of life care patients told us and we saw there was open visiting on the wards. Some relatives told us staff had arranged for them to stay overnight on a chair or bed available to visitors on the ward. Refreshments such as tea and coffee and snacks were available to relatives. Staff told us and we saw there was one relative's room per floor at City Hospital.
- End of life patients and their loved ones frequently had concerns about finances. The service worked directly with a Welfare Rights Advisor from Age Concern. Staff told us that patients who attended the day hospice could receive advice from this service.
- Mortuary staff told us there was a rapid release system at City Hospital for when certain faiths required a same day burial. Mortuary staff expressed concerns that due to deceased patients being released quickly from the hospital, there was potential for mistakes to happen.
- Mortuary staff told us if deceased patients did not have any family to arrange a funeral then the patient would remain at the mortuary until the relevant council arranged a funeral.
- Mortuary staff told us organ tissue donation could be arranged if necessary. Accident and emergency staff told us they had received organ donation training.
- Mortuary staff told us they had not received any specific training for preparing patients for specific religious requirements. Therefore, staff may not honour religious requirements of the deceased for example, as they are not aware of theses traditions due to lack of training.

Access and flow

- Data showed the palliative and end of life care service had received 1811 referrals between April 2015 and March 2016 of which 1255 patients (69%) had a cancer diagnosis and 556 patients had a non-cancer diagnosis (31%). This was a reduction of 74 patients from the previous year (2014-2015: 630 patients with non-cancer diagnosis).

End of life care

- Data received from the trust showed there had been 119 patients on an end of life care pathway between October 2016 and December 2016. Palliative care staff saw all of these patients within 24 hours of referral to the palliative care team.
- As of February 2017, 72% of patients had achieved their preferred place of death.
- Palliative care staff told us they have good access to the hub facilitators. Facilitators did not visit the wards at City Hospital every day like they were able to at Sandwell Hospital. However, staff told us they usually attended at City Hospital twice a week and would visit patients at City Hospital if ward staff requested.
- Staff told us end of life care facilitators were extremely flexible. They would visit end of life patients on wards, assess patients to determine if they should be on SCP, assess spiritual needs. Staff used the supportive and palliative care indicator tool to assess patients. The Connected Palliative Care Coordination hub ensured patients had timely access to treatment, support and care.
- End of life care facilitators provided a single point of access telephone service to provide clinical advice. A palliative care urgent response team, consisting of general palliative care nurses was available 24 hours a day, seven days a week to visit and support people who had been discharged from hospital and had asked to be cared for in their homes.
- Patients at end of life could be referred to the palliative and end of life care service directly via the connected palliative care coordination hub by carers, and health professionals on the wards. End of life care facilitators would then visit patients at end of life on the wards. Once they had assessed and reviewed the patient there was clear documentation in the patients' record of the visit and any recommendations made were written in those notes. End of life care facilitators would also discuss the patient's care with the medical and nursing teams caring for that patient.
- Ward staff told us and data we received from the trust showed patients rarely passed away before palliative and end of life care service had assessed them. Ward staff we spoke with were aware of the palliative care team's role and felt they were extremely responsive to requests for support.
- The palliative end of life service included a Macmillan therapy team who worked seven days a week. This team assisted in assessing patient's wishes and requirements to enable them to achieve their preferred place of care and death. The therapists carried out access visits to assess home circumstances and arrange any suitable equipment or aid to assist patient discharge.
- The trust's new partnership service had secured a 24 hours a day, seven days a week admissions to home from home beds (for EoLC) and hospice beds to two local hospices.
- Data received from the trust showed speed of rapid discharge could be as quick as four hours or up to 2 days depending on the care package needed by the patient. Palliative staff told us about an end of life patient whose preferred place of death was at home. Staff identified this patient was nearing the end of their life and arranged for all equipment the patient needed to be set up at home. This patient was discharged home within 24 hours.
- The trust operated an in-house transport service to prioritise transport for patients discharged at the end of life. The Macmillan therapy team supported this service.
- Ward staff could easily contact the connected palliative care coordination hub via telephone. Staff we spoke with said they could speak to the appropriate staff member at the hub quickly.
- The palliative and end of life care service had developed an end of life register held on an electronic patient record. The register was maintained by the end of life care facilitators who visited all ward areas, GP surgeries and community teams to review caseloads and ensure patients were identified at the end of life and recorded on the register if their consent was gained. The electronic patient reporting system also linked into GP practices in the Sandwell region.
- Staff told us the electronic end of life register was easy to use. Staff at the hub could easily monitor when patients were admitted and requested staff visited them. Staff told us it was very effective for the palliative and end of life care service.
- The palliative and end of life service also included an urgent response nursing team available 24 hours a day, seven days a week. This was a team of band 6 palliative care nurses who visited people at home and carried out visits when people were discharged from hospital to ensure they received appropriate care. Staff told us if palliative nurses identified rapid discharge was needed they would coordinate with discharge nurses to plan the discharge to ensure it happened as quickly as possible. They also assisted with rapid assessment by

coordinating with district nurses and the specialist palliative care and co-ordination hub. All patients were contacted within one hour of the request. They also visited patients admitted to the emergency department to ensure their admission was appropriate and to support the patient discharge if required. All patients with a supportive care plan were entered on the hospital electronic bed management system to ensure members of the MDT were aware of their enhanced needs. The end of life care facilitators audited patients on the supportive care plan to ensure suitable patients were included and the plan was appropriately used.

- There was a clinical nurse specialist (CNS) available seven days a week at City Hospital who worked alongside a consultant in palliative care. The service ensured experienced palliative care staff were available to provide advice to other professionals when required.
- Data received from the trust showed between 1 January 2017 and 31 March 2017, the hub contacted 100% of patients within 10 minutes of receiving the initial request, 100% of patients received a response within 30 minutes of a request from the urgent response team. First contact within one working day of receipt urgent referral was achieved for 86% of patients. This exceeded the trust target of 85%.
- Between October 2016 and December 2016, 100% of patients at the trust on an end of life care pathway were seen within 24 hours of referral to the palliative care team.
- City Hospital did not have a dedicated palliative care ward and end of life patients were cared for on a number of wards across the hospital. This did not affect the quality of care end of life care patients received as the palliative and end of life care service identified end of life patients on the wards via the hub.

Learning from complaints and concerns

- Between 1 April 2016 and 31 March 2017, the palliative and end of life care service had not received any complaints. Therefore the service had not had to review how they had managed and responded to complaints.
- Staff told us if a patient or relative raised any concerns they would try to resolve them locally by making their manager aware. Staff also told us they would direct people to the trust's patient advice and liaison team (PALS) if necessary.
- We saw learning from concerns was discussed during team meetings and at the quality improvement training.
- We reviewed the trust's policy on the handling of complaints and noted it was soon due for review in April 2017. Staff told us this was easily accessible on the trust's intranet.

Are end of life care services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The leadership, governance and culture of the palliative and end of life care service promoted the delivery of high-quality person-centred care.
- Staff told us the service leads were approachable and passionate about the service. They supported and motivated staff to deliver a high quality end of life/ palliative care service.
- The palliative and end of life care service lead received a SWBH 'star award', 2016 for being an 'outstanding new leader.'
- The service had met the strategy target to deliver an innovative, integrated end of life strategy 24 hours a day with partner agencies within both hospitals and the community.
- Senior staff regularly reviewed governance and performance management arrangements to identify and monitor risk to the service and staff followed best practice.
- Staff were proud of their palliative and end of life service. Staff at all levels told us the service had a positive culture, which was well managed by service leads.
- Service leaders actively sought to improve the service and kept abreast of updates nationally in end of life care.
- The trust had a clear vision and set of values for providing end of life care. The aim for the strategy for 2017 was for the palliative and end of life care service to become 'a beacon of excellence', continue to reduce unplanned hospital admission for end of life patients and research driven best practice.

However:

- Mortuary staff were concerned about lone working as the mortuary was separate to the main City Hospital building.

End of life care

Leadership of service

- The nurse manager led the palliative and end of life care service. Staff we spoke with told us there was good leadership of the palliative and end of life care service and they were highly respected. Staff told us leaders at every level were visible, approachable and supportive. Palliative and end of life care service staff told us their managers provided good emotional support when needed and they met regularly with their line manager. The chaplaincy team told us they do not receive many requests from palliative care nurses for support and stated "they must have very good line managers."
- Staff at all levels were passionate about the service and spoke highly of the service.
- The palliative and end of life service was part of the iCares directorate which is part of the Community and Therapies clinical group. A clinical group director, group director nursing, supported by the palliative and end of life service lead, led the senior management team for end of life and palliative care.
- The palliative and end of life care service leads had clear direction for the service with a service aim to deliver quality end of life care. We saw leaders had the experience and capability to ensure this service aim was met.
- The service lead for palliative and end of life care had a direct management responsibility for the lead nurse palliative care, the end of life facilitator lead, the therapy lead, the urgent response team lead and the project facilitator.
- The palliative and end of life care service had two consultants who oversaw the medical management of end of life patients.
- When the End of Life Care audit - Dying in Hospital, March 2016 was conducted, the trust did not have a lay member on the trust board with a responsibility for end of life care. This was one of two organisational key performance indicators (KPIs) the trust could not meet. However, at the time of our inspection the trust had since rectified this as the board now had an end of life lay member representative and an executive director and non-executive on the trust board.
- The trust Chief Executive was chair of the quarterly palliative care board meeting which included the trust end of life service and representatives from our partner organisations, local hospices and third sector providers. End of life care was also a key element of executive committees including the Quality and Safety Committee where the Chief Nurse represented end of life care.
- Ward staff, mortuary staff, porters and certificate and bereavement service staff told us they felt supported by their management teams and felt listened to if they raised any concerns.

Vision and strategy for this service

- The trust had a clear vision and set of values for providing end of life care. We saw the trust's five Year Strategic Plan, 2013 – 2018. The strategy included development of the palliative and end of life care service and implementation of the supportive care pathway (SCP). The aim for the strategy for 2017 was for the palliative and end of life care service to become 'a beacon of excellence', continue to reduce unplanned hospital admission for end of life patients and research driven best practice.
- Palliative and end of life care service and ward staff told us end of life care provision was a high priority for SWBH Trust.
- All staff we spoke with knew, understood and supported the trust's visions, values and strategic goals and how they could help achieve them. All levels of staff we spoke with were passionate about and understood the importance of providing patients with high quality end of life care that met their individual needs and choices.

Governance, risk management and quality measurement

- Trust data showed the iCARES directorate held monthly meetings where staff discussed governance quality issues concerning end of life care provision. There was also an annual in-depth quality and safety review of the performance of the division, which was undertaken annually.
- We saw minutes of five hub team meetings held in November 2016, January 2017, March 2017 (two meetings held this month) and April 2017. We saw from the minutes for April's meeting senior staff shared the risk management document from a recent iCARES Quality Improvement half days (QIHD). Senior staff requested all team members read and sign the document to ensure all staff were aware of and involved with risk management for the service.

End of life care

- The consultants within the team told us they regularly attended trust clinical governance meetings to discuss key developments, audit and governance in relation to end of life care.
- The acute and community specialist palliative care teams had meetings to discuss day-to-day operational issues.
- We saw that all patient deaths were reviewed as part of the weekly multidisciplinary team meeting. A consultant told us that they reviewed patients who had died to enable them to share what went well, act upon, and share what may be improved upon. Staff told us and we saw that a record of these meetings was made to enable staff that were unable to attend an opportunity to read the meeting notes.
- We saw records of governance meetings where senior staff reviewed complaints, incidents and the risk register. These were held at least quarterly. When necessary, staff shared findings with the directorate meeting for further action. Staff told us learning from complaints or incidents were then shared with them. The outcomes of these meetings were fed back to staff.
- We saw the palliative and end of life care risk register dated 3 March 2017 identified two risks to the service. These included:
  - Not delivering a seven-day visiting service despite investment from the clinical commissioning group due to staff vacancies and delays in the trust recruitment process.
  - Patients and other clinicians may not be aware to contact the hub and patients may be missed.
- We saw senior managers had action plans to address these risks. Responsible individuals had been allocated to each risk and reminder and staff recorded target dates on the action plans.
- We noted that there was an effective mitigation and management process of the risks identified.

Culture within the service

- Staff told us they were proud to work for the palliative and end of life care service and was committed to providing caring service to end of life patients. Another nurse told us the best part of the job was "seeing patients and the feeling of doing a good job."
- There was high levels of satisfaction across all staff. Leaders of the service encouraged compassionate, inclusive and supportive relationships among staff so they felt well respected, supported and valued.
- Staff we spoke with were committed to providing safe and good quality end of life care.
- The trust's lone working policy advised staff of actions to take to keep them safe. Palliative and end of life care service staff told us if they worked nights they had panic alarms and carried mobile phones.
- However, mortuary staff we spoke with were concerned they worked alone in the mortuary which was separate to the main hospital building. The trust had provided mortuary staff with rape alarms but staff said this was of little use, as they often had no staff visiting during working hours who would be in earshot. This was not in accordance with the trust's lone worker policy we reviewed which 'stated procedures, devices and/or safe systems of work should be in place to eliminate or reduce the risks associated with working alone.' This was not listed as a risk on the local risk register and we escalated this to senior managers during the inspection.
- Staff told us they felt confident to raise concerns with their managers if necessary and were confident they would be listened to.
- We found that staff sickness rates across palliative and end of life services in February 2017 3.8%, which was less than the national sickness average of 4.1%.

Public engagement

- The palliative and end of life care service regularly conducted surveys to obtain feedback from families and senior staff fed back the results at team meetings.
- The trust had sought patients and carers opinions to develop the palliative and end of life care service. The service was working with a local university to provide full evaluation including qualitative analysis with patients, carers and staff of the service provided.
- The trust was promoting the forthcoming 'Dying Matters Awareness Week 2017' to raise awareness of dying, death and bereavement.
- The palliative care and end of life service ran a 'Connected Palliative Care Awareness week' to highlight the role of the supportive care plan to patients in their last year of life.

Staff engagement

- The palliative and end of life care service held regular formal team meetings where information such as learning from deaths, incidents and audits could be shared.

End of life care

- We saw the palliative and end of life care service chaired Schwartz rounds for one hour each month. This was used as a forum for clinical and non-clinical staff from all backgrounds and levels to discuss the social challenges for caring for patients.
- The palliative and end of life care service ran a 'Connected Palliative Care Awareness week' and highlighted the role of the supportive care plan to patients in their last year of life.
- We saw the trust gave out a 'compassion in care award' each month to staff nominated by colleagues. An urgent response nurse from the palliative and end of life care service won this award for March 2017. The colleague who nominated this nurse who described them as "the most caring and compassionate nurse I have ever had the pleasure of working with."
- Staff told us they received a copy of the trust's magazine 'heartbeat' with their payslip to update them about the trust.
- Staff told us and we saw that there were QIHDs where staff discussed strategic and developmental quality initiatives within the service, which affected the delivery of end of life and palliative care services.

Innovation, improvement and sustainability

- Information from the palliative and end of life care service outlined it had recently given a presentation about the service at a recent Department of Health roadshow. The presentation was rated second overall. The service received positive comments and other hospitals were keen to adopt the service for themselves.
- The palliative and end of life care service had been nominated for the National Council for Palliative Care Awards, 2017. These health and social sector care awards recognise "exceptional people and services that have made a real difference through outstanding care, support and commitment to end of life care in England, Wales and Northern Ireland during 2016."
- The palliative and end of life care service lead received a SWBH 'star award', 2016 for being an 'outstanding new leader.'
- The palliative and end of life care service delivered a partnership model with third sector organisations. The partnership provided a patient focused individualised, holistic service able to provide respite, domestic support and specialist hospice beds in addition to the specialist palliative care.
- The urgent response team was available 24 hours a day, seven days a week. This enabled the service to rapidly respond to patients needs when they most needed support. This gave end of life patients the choice to die at home with their symptoms controlled.
- The end of life register coordinated by end of life facilitators had enabled end of life patients to be identified and receive timely and appropriate care and treatment in their preferred place of care.
- The supportive care plan for end of life care had been reviewed and relaunched and was available throughout the trust.
- The palliative and end of life care service had systems in place to review and develop service delivery. In addition, the service ensured lessons were learned and actions were taken to ensure the service provided excellent end of life and palliative care.
- The service identified a number of improvements from the results of their audit of why end of life patients preferred place of death (PPD) was not achieved between 1 April 2016 and 31 October 2016. This demonstrated the service were keen to constantly improve the service they provided to end of life patients.

Outpatients and diagnostic imaging

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

Information about the service

There are two Outpatient and diagnostic imaging services delivered from City Hospital, One from the main hospital site and a second from Birmingham Midland Eye Centre (BMEC). We have reported on them separately under each domain.

For City Hospital Outpatients and Diagnostic Imaging:

Outpatient clinics are located on the ground and first floor of The Birmingham Treatment Centre. There is a main reception area on the ground floor, with additional reception desks on the first floor. The diagnostic imaging department includes X-ray, CT (computerised tomography) scans, interventional imaging, fluoroscopy, ultrasound and nuclear medicine. Management and staffing rotate across both acute hospital sites (City and Sandwell General). Between November 2015 and October 2016 there were a total of 379,777 outpatient appointments.

The outpatients service at City Hospital was previously inspected in October 2014 as part of the CQC comprehensive inspection programme. The service was rated as inadequate for safe, responsive and well-led. Caring was rated at good. The overall rating was inadequate. There was a breach of the Ionising Radiation (Medical Exposure) Regulations 2000 as there was a lack of staff training records. Reporting times for completed imaging were delayed. The inspection team returned October 2015 to City Hospital and saw significant improvements had been made across all areas of the service. During this inspection we found improvements had been maintained and were well embedded

During our inspection, we observed a range of outpatient clinics, including breast, cardiology, respiratory, children's, oncology, and Ear, Nose and Throat (ENT). We spoke with 11 patients, 46 members of staff including managers, consultants, radiologists, clinical nurse specialists, nurses, allied health professionals, bank staff, and volunteers .We reviewed 10 patient records.

For Birmingham and Midland Eye Centre (BMEC):

The Birmingham and Midland Eye Centre (BMEC) is located in a stand-alone building on the trust's City Hospital site. As well as taking referrals from GPs and non-specialist hospitals, it is a 'tertiary referral centre'. This means it accepts referrals of the sickest, most clinically complicated ophthalmology patients from specialist eye centres throughout the country.

Outpatients departments at BMEC conducted 166,003 appointments during 2016/17.

During our inspection we spoke with 23 members of staff, and 13 patients and visitors.

Outpatients and diagnostic imaging

Summary of findings

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC):

We rated this service as good because:

- We saw that staff reported the majority incidents of all levels and staff we spoke with were clear of the policies and procedures around this.
- We saw that all areas were visibly clean and tidy and that there were processes in place to ensure these standards were maintained.
- We saw that equipment was risk assessed and tested to ensure all risks were minimised
- We saw examples of positive multi-disciplinary working and staff told us this was consistently good across the trust.
- Policies and guidelines used were up to date, relevant and staff had access to them.
- In the imaging department local Diagnostic Reference Levels (DRLs) had been established, were reviewed regularly and reduced by the medical physics service whenever possible. We saw evidence that DRLs were discussed in IRMER committee meetings and we saw that mostly these were better than the national average.
- We saw staff fully explained the process for assessment, examination and diagnosis and treatment in a clear way for the patient to understand. Patients we spoke with told us they had felt fully involved throughout their consultations and treatment.
- We saw examples of innovation that would improve patient experience.
- Extra clinics took place throughout the day and during the evenings to meet the demand of services and to reduce waiting times for patients.
- The BMEC waiting area and processes for appointments had certain adaptions in place to meet the needs of patients using this specialist building. This included colour coded waiting areas, one-stop clinics, induction loops for the hearing impaired and a designated car park.
- Staff told us that their local managers were supportive and worked with them towards improving care for patients. All of the staff we spoke with told us they felt they could raise issues with senior staff if they needed to.

However:

- Resuscitation trolleys were left open in patient areas and did not have tamperproof tags.
- We saw that patient records were at times left on trolleys or desks unattended. This meant that staff were not always protecting patient confidentiality.
- Staff in the outpatients department did not have their competencies regularly assessed to ensure they were confident and competent to carry out their role.
- The layout of the consulting rooms in the BMEC orthoptics department did not always ensure patient's privacy and dignity were protected.
- There were no chaperone notices in any of the outpatient areas.
- Staff told us that clinics often went over the scheduled time and patients could therefore be waiting longer than expected.
- There had been a workforce review of staffing for the service across all OPD services which had led to significant changes in the two years prior to the inspection. Staff told us they had not felt part of this and that they felt unaware of the strategy for the future of the service.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC):

We rated safe as good because:

- We saw that staff reported incidents of all levels and staff we spoke with were clear of the policies and procedures around this.
- Staff told us that there had been shared learning from incidents across sites and departments when relevant to their role.
- We saw that all areas were visibly clean and tidy and that there were processes in place to ensure these standards were maintained.
- We saw that equipment was risk assessed and tested to ensure all risks were minimised.

However:

- Resuscitation trolleys were left open in patient areas and did not have tamperproof tags.
- We saw that patient records were at times left on trollies or desks unattended. This meant that staff were not always ensuring patient confidentiality.
- Staff we spoke with were unaware of the major incident policy, told us they had not had any training for many years and did not know what their specific role would be in the event of a major incident.

Incidents

For City Hospital Outpatients and Diagnostic Imaging:

- Never events are serious patient safety incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. From February 2016 to January 2017 there were no never events reported for the OPD and DI at City Hospital.
- In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England between February 2016 and January 2017.
- There were 485 incidents reported by staff in the OPD and DI across the trust during the reporting period. Of these staff had graded 20 as severe harm, 153 as low harm, 256 where no harm occurred and 56 were recorded as a 'near miss'.
- The most frequent type of incident reported was incorrect examination in radiology with 35 incidents reported. There were 31 'organisational issues' and 27 incidents of communication failure between trust staff.
- Staff told us that there were between 15-20 incidents per year involving patients falling on the escalator in the Birmingham Treatment Centre and that they felt this was a significant issue for their department. We spoke with the manager who informed us that this was an ongoing issue that was incident reported appropriately. The data provided by the trust showed that between February 2016 and January 2017 there were only three incidents reported relating to the escalator and therefore differed from the information provided by staff.
- Staff we spoke with were clear of the policies for incident reporting, knew how to report and told us that they did so when necessary. Staff showed us the electronic incident reporting system that was available on the trust intranet.
- Staff told us that they usually received feedback from incident reporting if there was learning or if it were relevant to the department. Managers provided feedback directly to staff or through monthly learning sessions. We saw minutes from the meetings and saw that information in regards to incidents was not always recorded in detail. Staff told us that they would receive verbal information about this from their manager if they had not been able to attend the meeting.
- The trust had established an IRMER committee to ensure the trust complied with the ionising radiation (Medical Exposures) Regulations 2000.The committee met four times a year and monitored, analysed and reported on radiation incidents. We reviewed the committee latest annual report (2015) and saw incident trends were included. The report highlighted one trend as being 'referrer wrong patient'. Staff in the imaging department had taken actions to address this such as the six point ID procedure and a screensaver highlighting incidents to trust staff.
- Duty of candour (DoC) relates to openness and transparency and requires providers of health and social care services to notify patients, or other relevant

persons, of certain notifiable safety incidents and provide support .Staff we spoke with were unclear of their role with the DoC requirements however told us they were always open and honest with patients and their relatives.

- We saw that there had been three incidents that had led to the DoC being followed and we saw that the trust had issued a letter that contained relevant information and an apology to the patient.
- We saw that there was a policy in place called 'being open following a patient safety incident'. The policy contained guidance on saying sorry, a being open flowchart and information on existing requirements regarding openness.

For Birmingham and Midland Eye Centre (BMEC):

- From April 2016 to March 2017 one never event had been recorded at BMEC. All the staff we spoke with were aware of the incident. Senior managers told us an immediate debrief had been carried out with the staff involved, and the matter had been investigated by the trust's governance team and lead never event committee. Once the investigating staff member had concluded the investigation the staff member shared the report and recommendations with BMEC staff and the trust wide patient safety committee to prevent a repeat occurrence.
- Root cause analyses of more serious incidents reported in BMEC were conducted by a nominated department manager. However, the manager had not completed any training to carry out root cause analyses, and we could not be assured the process was being performed effectively.
- A senior manager in BMEC told us the process for sharing learning from incidents depended on their severity, and the timescale of the incident. Where appropriate and possible, they said there would be an immediate debrief with staff who were involved, followed by a formal investigation. Learning was shared at quality improvement half days (QIHDs), via the trust wide 'serious incidents' group, patient safety committee, nurse educators and the trust intranet 'safety brief'. Senior managers told us that senior staff shared local incidents during nursing and medical handovers, and as part of safety huddles.
- Staff at BMEC also told us senior staff shared learning from incidents with them at QIHDs and via the trust's 'safety brief'.
- Senior managers in BMEC demonstrated a good understanding of their obligations under duty of candour. Most junior staff we spoke with did not have an in-depth knowledge of the process, but generally described it as being 'open and honest with patients if something went wrong'.

Cleanliness, infection control and hygiene

For City Hospital Outpatients and Diagnostic Imaging:

- Staff we spoke with were aware of the trust policy on infection control and how to access this through the trust intranet.
- We saw that clinic rooms and waiting areas were visibly clean, tidy and uncluttered.
- We saw that daily cleaning took place as well as deep cleaning as and when required. We saw cleaning checklists for staff to follow however, staff did not sign these off daily.
- Staff were responsible for maintaining the cleanliness of clinic rooms throughout the day and we saw that they did so in accordance with infection prevention and control (IPC) standards
- If cleaning was required throughout the day facilities staff were available on call to attend to this.
- Ward service officers ensured they maintained cleanliness standards by completing monthly audits in the OPD department.
- The hospital overall scored 99% on patient led assessments of the care environment (PLACE) scores in relation to cleanliness in 2016. This was slightly higher that the national average of 98%. The assessments involved local people going into hospitals to assess how the environment supports patients privacy and dignity, food, cleanliness and general building maintenance.
- There were sufficient hand-washing facilities and hand gels in consulting rooms and we saw patients and visitors were encouraged to use these.
- We saw personal protective equipment (PPE) including gloves and aprons were available for staff in line with the infection prevention and control policy. We also saw staff using this equipment appropriately when examining patients.
- We observed staff cleaned equipment appropriately in-between patients.
- We saw all staff followed the arms bare below the elbow policy apart from two consultants who were working in clinics.

- We saw that hand hygiene audits were conducted across the OPD. Six audits were completed between February 2016 and February 2017 in the Birmingham Treatment Centre. The overall average was 95% with August 2016 having the lowest score of 79%.
- We saw that leaders in the x-ray department completed monthly hand hygiene audits. The compliance rate was above 90% for all months aside from April 2016 where it was 50%, November 2016 at 38% and December 2016 at 55%.
- Staff told us patients with infections were isolated from other patients and when medically appropriate they would offer scan appointments for infectious patients at the end of the day.

For Birmingham and Midland Eye Centre (BMEC):

- All clinic areas in BMEC outpatients were visibly clean. We saw staff using hand cleansing gel or washing their hands regularly, and before and after each patient contact. This complied with the World Health Organisations 'five moments for hand hygiene' guideline.
- We saw hand cleansing gel available for staff, patients and visitors in all areas of BMEC outpatients, together with notices encouraging its use.

Environment and equipment

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC):

- The hospitals PLACE score (2016) for condition, appearance and maintenance was 97%; this was slightly higher than the national average of 93%.
- The clinic rooms were suitable for use and well maintained. All of the consulting rooms we saw were fully compliant with both HBN 00/9 infection control in the built environment and HBN 00/10 Part A flooring.
- We saw that the trust serviced equipment in line with manufacturer guidelines. There was a managed equipment service agreement in place in the diagnostic imaging department where equipment was automatically serviced.
- All of the equipment we saw was up to date with electrical safety testing.
- We checked all of the resuscitation trolleys which were visibly clean and ready for use. We saw records that showed staff checked equipment daily. However, we noted that these trolleys were not locked and did not have tamperproof tags.
- We saw appropriate use of sharps bins in clinic rooms. We saw that sharps bins were stored in rooms in the main outpatient area, during the inspection we saw three of these rooms were unlocked with the doors open and sharps bins left on the floor along with clinical waste in unlocked storage bins. We raised this with staff who immediately locked the doors and told us that staff would be reminded to ensure they remained closed.
- We found that in two areas items that should have been stored under the Control of Substances Hazardous to Health (COSHH) were in unlocked cupboards accessible to patients. We raised this with staff during the inspection and when we returned to the areas they had been moved and stored appropriately.
- We saw that staff managed waste appropriately within the imaging department and that all documentation was in place to evidence this.
- We spoke with staff about the risk assessment of legionella within the department. As testing had given sight of potential risk the taps were all fitted with filters to mitigate this. We spoke with staff from the estates department who provided evidence of flushing regimes and water sampling. This showed that the trust was managing the risks in relation to legionella appropriately.
- We saw evidence that staff in the diagnostic imaging department completed risk assessments prior to the use of new or adapted imaging equipment. This ensured that the risks of radiation were minimised.
- There was a 'managed equipment' service (MES) agreement in place for imaging facilities for servicing and maintenance of equipment and staff told us this worked well. The medical physics team also worked with imaging and the MES to ensure that standards were maintained with the upkeep of the x-ray room and nuclear medicine cameras.
- We saw that there were sufficient lead aprons and personal protective equipment available for each room within the diagnostic imaging department. We saw that these were stored correctly and that there was evidence to show these were checked annually to ensure they were fit for purpose.

Outpatients and diagnostic imaging

Medicines

For City Hospital Outpatients and Diagnostic Imaging:

- A medicine optimisation policy dated January 2016 detailed arrangements for prescribing, requisition, storage, administration and control of medicines. The trust had shared the policy across the intranet to enable staff to have direct access. We checked the drug cabinets during the inspection and found that all medicines were stored appropriately. The medicines we saw were within expiry dates.
- We saw documentation that showed staff checked refrigerator temperatures daily and that recording were within the recommended range of 2-8°C. However, staff did not monitor temperatures of the rooms where drug cabinets were. Keeping room temperature records demonstrates that medicines are stored safely and is good practice.
- Staff were all aware of the protocols with ensuring medicines were stored securely.
- Staff told us they could not recall issues with medicines stocks.
- We saw that there were arrangements in place for the safe storage and tracking of prescriptions for controlled drugs.
- We saw that there were arrangements in place for the safety of controlled drugs and chemotherapy given in outpatients.
- We saw that there were environment agency licences in place for all radiopharmaceuticals used and that these were stored and used appropriately.
- The nuclear medicine department at the trust had two full time consultants and a consultant radiologist who had an Administration of Radioactive Substances Advisory Committee licence (ARSAC).
- Senior staff told us that the nuclear medicine consultant and the consultant physicist in nuclear medicine have both served as members of the ARSAC committee and that all nuclear medicine protocols had been authorised by the ARSAC nuclear medicine consultant. This ensured that the department took the medicines (Administration of Radioactive substances) Regulations 1978 (MARS) into account.
- There had been no medicines audits conducted within the outpatients or diagnostic imaging departments in the twelve months prior to the inspection.
- There was a pharmacy at City Hospital open Monday to Friday 9am to 5pm, Saturdays 10am to 12:30pm and Sundays 10am to 1:30pm.

For Birmingham and Midland Eye Centre (BMEC):

- The pharmacy department was situated near the front of the hospital but was very small for the requirements of the service. Pharmacy staff appeared to work well within the small space and made the best use of all available areas.
- Pharmacy staff checked medicines were prescribed appropriately, that patients were not allergic to any of the ingredients and had been told how to self-administer medicines such as eye drops.
- Prescription forms were stored securely in the department.

Records

For City Hospital Outpatients and Diagnostic Imaging:

- The service used paper patient records, we reviewed 10 sets from across the outpatient and diagnostic imaging departments. All the records were legible, signed, dated and contained the relevant information including completed consent forms, risk assessments and patient allergies.
- Medical notes were stored off site at a secure storage facility, staff requested sets of notes in advance of appointments.
- Staff told us and we saw that patient referral letters were not always available. When this occurred staff would access the system to review the scanned copy.
- Staff told us it was unusual for records to be unavailable for consultations however would make a temporary record file if this were the case and add it to the patient file when available. We saw results of records audits that showed over 99% of patient's notes had been available from September 2016 to February 2017.
- The trust were in the process of moving to an electronic patient record system. The trust was due to implement this in June 2017.
- We saw that at times staff left patient records unattended on trolleys that were accessible to patients. This meant that patient confidentiality and the security of notes could not be ensured.

- Diagnostic images were electronically stored on a picture archiving and communication system (PACS). This enabled staff to share images throughout the trust and departments.

For Birmingham and Midland Eye Centre (BMEC):

- BMEC used paper patient records, which were stored off-site at a secure storage facility. Staff ordered patient records in advance of patients' appointments; however, staff told us they frequently experienced problems with notes being delivered in time.
- Senior managers told us they were aware of problems with availability of patients' notes for clinics, and that in the past senior staff had had to cancel clinics because of this. However, the trust told us from April 2016 to March 2017 no clinics had been cancelled. Managers told us the trust's move to an electronic patient records system would eliminate this problem as records would no longer have to be physically moved from storage for clinics.
- We looked at 48 sets of patient records during our inspection of BMEC. We found they were comprehensive, legible, entries were dated and signed by the member of staff completing the record.

Safeguarding

For City Hospital Outpatients and Diagnostic Imaging:

- We saw there were policies in place for the Safeguarding of adults and children. Policies contained information on types of abuse, staff roles and responsibilities and flow charts on actions staff should take.
- Staff we spoke with were aware of the types of concerns that may require them to raise safeguarding concerns. Although staff told us they would gain support from their manager if they had concerns, they were unaware of who the safeguarding leads were in the trust and unclear of the process to follow.
- Safeguarding training was part of the mandatory training programme.
- Data provided by the trust showed that across all three sites 96% of staff had completed Safeguarding Adults Level 1 training. We saw that 84% of staff had completed Safeguarding Adults Level 2 training. The overall figure for completion of Safeguarding Children Level 1 training was 97%. For Safeguarding Children Level 2 it was 80%. The figure for completion of Safeguarding Children Level 3 was 92% against a target of 95%.
- The trust employed three staff that were qualified in delivering workshops to raise awareness of 'Prevent'. Prevent aims to reduce the number of people becoming or supporting violent extremists and is part of the UK's counter-terrorism strategy.

For Birmingham and Midland Eye Centre (BMEC):

- The trust ensured that, non-clinical staff in BMEC had training in level 1 safeguarding vulnerable adults and children, clinical staff had level 2 safeguarding children, and department managers had level 2 safeguarding vulnerable adults. Records showed 100% compliance with level 1, and level 2 safeguarding children training. Compliance with level 2 safeguarding vulnerable adults stood at 50%, however only two members of staff needed to train to this level, so only one was outstanding.

Mandatory training

For City Hospital Outpatients and Diagnostic Imaging:

- The trust delivered a mandatory training programme that included modules such as health and safety, infection control and basic life support. The outpatient service across all three sites was at 89% completion of this training programme. This was lower than the trust target of 95%.
- During the inspection staff informed us that there were issues with access to fire safety warden training and so the figure for this was at 0% across five areas.
- At the City Hospital site, the training completion figure for basic life support in the hearing services centre was at 0%. Staff told us they were waiting for the training to become available as the trust was going to roll out the training on line; staff told us that this was a trust wide issue. This was also reflected in low completion rates across all other areas aside from the bowel cancer screening department where the figure was 100%.

For Birmingham and Midland Eye Centre (BMEC):

- Overall, BMEC outpatients' staff had achieved over 95% compliance in all mandatory training courses apart from conflict resolution update, which stood at 89%, basic life support at 75% and an information governance refresher, at 33%.
- A nurse educator in BMEC told us the trust's electronic staff records (ESR) system sent them an email every Monday, containing a spreadsheet of mandatory

training compliance. Nurse educators followed up staff who had training due or overdue, which were highlighted in orange or red respectively, however they told us there was a delay between staff completing training and ESR being updated, so actual completion figures were usually better than those shown on the spreadsheet. They told us staff were responsible for their own compliance with mandatory training, and were able to log on to ESR and check their own records. They said staff were able to take protected time for training, but that most completed it during less busy times, between or after clinics.

Assessing and responding to patient risk

For City Hospital Outpatients and Diagnostic Imaging:

- We saw the trust guidance for staff to follow should a patient's condition deteriorate whilst in the outpatients department. This was clear and staff were aware of the protocol to follow if this occurred including the telephone number for the emergency team.
- Resuscitation equipment was available with signs in waiting areas for staff to know where the nearest trolley was located. Staff checked these daily and we saw from the records that this was the case. However, we saw that the equipment was not kept locked and with tamperproof tags.
- We saw evidence that new equipment and procedures in the radiology department were risk assessed. We reviewed a risk assessment in relation to new x-ray equipment being installed that carried a risk of ionising radiation. The risk assessment considered the risks to employees, operators and members of the public and described the control measures staff had been put in place to reduce any risk.
- The diagnostic imaging department had procedures in place to ensure that staff did not unnecessarily expose foetuses to ionising radiation. The procedure references questions staff needed to ask and advised staff on the different routes to take in different scenarios.
- Staff in the diagnostic imaging department used The World Health Organisation (WHO) interventional radiology checklist appropriately. We saw completed documentation that showed the use of this. We saw the results of an audit that showed 100% compliance between April 2016 and March 2017.
- The imaging department had guidelines in place for the prevention on contrast induced nephropathy. Additionally the department had a standard operating procedure (SOP) for determining patient suitability prior to intravenous administration of iodinated contrast.
- We saw evidence that there were radiation supervisors available in several areas.
- We saw signage in place to alert staff and the public of ionising radiation in the diagnostic imaging department.

For Birmingham and Midland Eye Centre (BMEC):

- BMEC doctors had reviewed records of patients living with glaucoma who were overdue for follow-up appointments, and graded them according to risk. The department prioritised patients with the highest risk rating for follow-up assessments.
- Orthoptists in BMEC outpatients had devised a checklist, printed on stickers attached to patients' notes, showing a list of 'red flag' escalation triggers. The checklist had started as a training 'aide memoire' for junior staff, however it had been found to be effective and adopted for use by all staff. Staff told us its use had been audited and found to be 100%.
- In line with the hospital's policy, staff in all areas at BMEC had access to basic life support equipment. In the event of an emergency, the hospital's resuscitation team would be called to attend from the main building, using the trust's emergency call number.

Nursing staffing

For City Hospital Outpatients and Diagnostic Imaging:

- The senior sister was responsible for establishing staffing levels and skill mix in the outpatient's department. There was no acuity tool used to determine staffing levels, this is not unusual in outpatient departments. The sister considered the number of patients and the level of patient interaction required when deciding what staffing levels were required. A workforce review took place in 2013. The outcome of this led to staff working across both Sandwell and City Hospital sites and the registered general nurse (RGN) to Healthcare Assistant (HCA) ratio was set at 20:80. This meant that for each nurse working in the department there were four HCAs.
- Staff told us they had concerns about the lack of RGNs across the department especially when there were high risk patients attending.

- There were 82.3 WTE nursing staff in post as of February 2017. The vacancy rate for nursing staff was 8.1%.
- Sickness rates from January 2016 to December 2016 was 6.0% this was higher than the trust target of 2.5%.
- The turnover rate for nursing staff between February 2016 and January 2017 was 12.1% this was slightly higher than the trusts target of less than 11.7% per year.
- Bank usage in the outpatient and diagnostic imaging departments varied between 0% and 17%. The average was 8.5%. The highest bank staff usage occurred in August, November and December 2016 (17%). The departments with the highest use of bank staff over the period were radiography, ultrasound and the trauma and orthopaedics fracture clinic.
- There were nine Whole Time Equivalent (WTE) Band 7 radiographers in post across the trust. There were 27 WTE Band 6 radiographers, 15.8 WTE Band 5 radiographers and two WTE Band 4 assistant practitioners in post.
- The vacancy rate was 14.8 WTE for Band 5 radiographers, 0.5 WTE for Band 6 radiographers and 0.6 WTE for Band 4 assistant practitioners. The trust were advertising the vacancies and the group director told us they were confident they would fill most of these with newly qualified staff on completion of their studies.
- Staff told us that there had been pressure on the imaging department due to the vacancies however felt that there had been improvements during the twelve months prior to the inspection. They were positive about the plans in place for recruitment.
- Radiographers were available 24 hours a day and worked short, long and night shift patterns.
- Sickness levels in radiology were 4.5% which was slightly higher than the trust average.

For Birmingham and Midland Eye Centre (BMEC):

- We saw all outpatients clinics at BMEC had sufficient nursing, allied healthcare and support staff to provide a safe service for patients.
- BMEC outpatients did not use any agency nurses. BMEC staff who worked on the trusts bank covered vacant shifts in the centre. BMEC outpatients had a vacancy rate of less than 3% for nursing staff, made up of 3.06 whole time equivalent (WTE) band 5 nurses and 0.8 WTE band 2 healthcare assistants. At the time of our inspection, the trust had appointed a part time band 5 nurse but they had not yet started work. When the part time nurse stated, the band 5 vacancy figure would drop to 2.5 WTE.

Medical staffing

For City Hospital Outpatients and Diagnostic Imaging:

- Medical staff were employed into the speciality and therefore not attributed to OPD.
- At the time of the inspection the vacancy rate for medical staff was 7.9%.
- We spoke with staff who told us medical staffing levels in clinics were sufficient with the frequent use of locums staff. Medical staff covered additional clinics when required to meet waiting time targets.
- Between February 2016 to January 2017, the trust reported a turnover rate of 18%.
- Between February 2016 and January 2017 the trusts locum usage varied between 0.5% at its lowest and 3.5 % in July 2016.

For Birmingham and Midland Eye Centre (BMEC):

- Senior managers at BMEC expressed concern about reductions in medical staffing in the centre. They told us consultant numbers had reduced by 33% over recent years, and consultant neuro-ophthalmologist numbers had dropped from five in 2015/16 to one.
- The orthoptics department at BMEC had one consultant, shared with a neighbouring NHS trust. This limited the number of clinics the department ran; however allied health professionals ran screening clinics which supported the process.
- BMEC outpatients used two long-term locum middle-grade doctors.
- BMEC employed 8.8 whole time equivalent doctors of different grades, in different specialties. The doctors were supported by allied health professionals to provide a safe service for patients.
- We asked the trust for details of medical staffing vacancies in BMEC, however the data they supplied was unclear. The figures they provided gave the establishment for medical ophthalmology as zero, and actual staffing as two whole time equivalent. This did not reflect details of the numbers of doctors employed in BMEC, as above.

Major incident awareness and training

Outpatients and diagnostic imaging

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC)

- We saw the trust wide major incident policy. This outlined the plan for staff across all sites rather than being specific to the OPD at City Hospital.
- Staff we spoke with were unaware of the major incident policy, told us they had not had any training for many years and did not know what their specific role would be in the event of a major incident.
- The trust provided staff with personal alarms following an incident in the department that had led to concerns about staff safety. Staff told us they were reassured by the measures put into place and felt safe working at the site.

Are outpatient and diagnostic imaging services effective?

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC)

The department was inspected but not rated for effective as we are currently not confident we are collecting enough evidence to rate the effectiveness of outpatients and diagnostic imaging services.

- Policies and guidelines used were up to date, relevant and staff had access to them.
- In the imaging department local Diagnostic Reference Levels (DRLs) had been established, were reviewed regularly and reduced by the medical physics service whenever possible. We saw evidence that DRLs were discussed in IRMER committee meetings and we saw that mostly these were lower than the national average.
- The overall trust follow up to new appointment rate of 1.4 was one of the lowest rates in England.
- Staff received training and there were formal processes in place to ensure this. The departments kept records to evidence this.
- National courses for nuclear medicine ran from the City Hospital site and staff had access to these as well as the opportunity to participate in research.
- We saw examples of positive multi-disciplinary working and staff told us this was consistently good across the trust.
- We saw that staff working at BMEC were supported by the nurse educator with training, competencies and revalidation.

However:

- Staff in the outpatients department at City Hospital did not have their competencies regularly assessed to ensure they were confident and competent to carry out their role.

Evidence-based care and treatment

For City Hospital Outpatients and Diagnostic Imaging:

- We saw that policies and guidelines were available through the intranet. We saw that staff were able to access computers to view these.
- We reviewed policies and saw that the trust had based these upon National Institute for Health and Care Excellence (NICE) guidelines. Staff told us they worked to these policies and guidelines, were able to give examples and had regular updates of any changes.
- We saw evidence that the trust conducted audits to assess compliance with NICE guidance. This included the assessment of compliance with NICE CG153 for the assessment and management of psoriasis. The audit was conducted in March 2015 and found that the national standards were not being met. Recommendations included the design and implementation of a new psoriasis baseline/annual proforma to cover all cardiovascular screening questions and to establish a dedicated psoriasis clinic. A re-audit had not been completed to assess any improvements following actions taken.
- A re-audit of compliance with NICE Quality Standard 52 peripheral arterial disease in March 2016 showed that the standard of all patients being offered angioplasty when imaging confirmed suitable was being met. However, due to the limited number of patients referred for angioplasty it was not possible to gain a true reflection of clinical practice within the service.
- The interventional radiology checklist adopted from the World Health Organisation (WHO) surgical checklist was used within interventional radiography. We saw this in practice and also reviewed completed documentation.
- Clinical staff we spoke with had a good understanding of Ionising Radiation (Medical Exposure) Regulations 2000 relevant to their area.

- Local Diagnostic Reference Levels (DRLs) had been established. They were reviewed regularly and reduced by the medical physics service whenever possible. We saw evidence that DRLs were discussed in IRMER committee meetings and we saw that mostly these were lower than the national average.

For Birmingham and Midland Eye Centre (BMEC):

- Treatment provided for patients at BMEC followed clinical guidelines published by the Royal College of Ophthalmologists and the National Institute for Health and Care Excellence.
- From April 2016 to March 2017, BMEC offered 63 different types of assessment or treatment in outpatients. Staff performed a total of 15,145 assessments and treatments during this time.
- BMEC outpatients provided a range of diagnostic imaging services. These included: anterior segment photography, corneal tomography, ocular wavefront analysis, specular microscopy, in vivo confocal microscopy, optical coherence tomography, fundus photography, scanning laser ophthalmoscopy, fundus auto fluorescence, laser Doppler flowmetry, retinal oximetry, ocular and orbital ultrasound and ultrasound biomicroscopy. All the imaging procedures provided in BMEC followed the Royal College of Ophthalmologists 'Ophthalmic Services Guidelines - Ophthalmic Imaging, November 2016'.
- BMEC ran a specialised clinic for people living with Behçet's syndrome, a rare, chronic auto-inflammatory multisystem disorder of unknown cause. The clinic was a national centre of excellence of treatment of the condition.

Pain relief

For City Hospital and BMEC Outpatients and Diagnostic Imaging:

- Staff told us, and we saw from patient records, that staff administered appropriate pain relief when necessary.
- We observed consultations with patients and although we did not see pain relief administered we saw that patients were asked about their pain and given advice about how to manage this.
- If patients required ongoing pain relief doctors prescribed this during clinics. Patients could collect their prescription from pharmacies located at City Hospital and in BMEC.

Facilities

- The BMEC outpatients department had a coffee shop and cafeteria-style seating area, where patients were welcome to eat food purchased in the department or brought in with them from home.

Patient outcomes

For City Hospital Outpatients and Diagnostic Imaging:

- The oncology unit participated in the neutropenic sepsis audit. Results of this showed that the unit was 100% compliant with meeting the 1 hour door to needle time in March 2017.
- The trust had several departments currently participating in the Improving Quality in Physiological Services (IQIPS) accreditation. These included audiology, cardiac physiology, gastrointestinal physiology, neurophysiology, ophthalmic and vision science, respiratory and sleep physiology, urodynamics and vascular science.
- Between November 2015 and October 2016, the follow-up to new rate for Sandwell General Hospital and City Hospital was lower than the England average. The overall trust rate of 1.4 was one of the lowest rates in England.
- At the time of the inspection the hospital was not participating in the Imaging Services Accreditation Scheme (ISAS). The radiology group director told us this was part of the future vision but there were no current plans to start this process.

For Birmingham and Midland Eye Centre (BMEC):

- The BMEC orthoptics department audited outcomes for patients who were referred to the clinic following a stroke. The audit asked six questions about the patients' understanding of and worries about their condition before and after their appointment with an orthoptist. The responses to the questions showed a significant improvement in all areas after the appointment.

Competent staff

For City Hospital Outpatients and Diagnostic Imaging:

- There were formal processes in place to ensure staff had received training and the trust kept records to evidence this. However, staff in the outpatient department did not have their competencies assessed to ensure they were confident and competent to carry out their role.

- Managers told us that the trust was developing a three year plan for nurses, this included nurses attending university to update their skills. We spoke with bank staff who told us they had received a good induction to the department and had participated in mandatory training.
- Senior staff told us that staff in outpatients had completed training in different areas such as taking bloods and that staff completed the care certificate. The care certificate is a set of standards that social care and health workers abide by during their work.
- We saw robust documentation of checks of staff competencies in the diagnostic imaging department that included ensuring cardiologists, radiologists, registrars and agency workers were competent with using the equipment.
- We saw there was a cardiac catheterization training manual for staff to work through which included specific equipment; once competent senior staff signed them off.
- We saw records that showed 82% of staff working in the outpatients and diagnostic imaging departments had completed an appraisal. The trust target for appraisals was 100%. Staff told us they saw this process as useful and that it was an opportunity for them to discuss development and opportunities.
- The services had monthly learning afternoons where various topics were covered. Staff told us these were valuable and informative.
- Staff told us that managers gave them time to complete online training and that there was funding available for some additional training.
- Registered nurses told us they had completed 'Nurse MOT's, which involved refresher training and checks to review and update skills. However, this did not apply to all staff and was not checked by managers of the service.
- Staff told us that the trust supported them through the revalidation process and that there were leads within the team to go to for advice if necessary.
- National courses for nuclear medicine ran from the City Hospital site and staff had access to these as well as the opportunity to participate in research.

For Birmingham and Midland Eye Centre (BMEC):

- One member of staff in the orthoptics department at BMEC told us they had "incredible" opportunities to develop, partly due to the interesting and varied caseload the clinic dealt with from the emergency department, GPs and tertiary referrals. Another told us they had more support for additional training and development than colleagues who had graduated at the same time, who worked at other providers.
- Staff told us allied health professionals (AHPs) in BMEC could train as glaucoma specialist practitioners if they chose to. Glaucoma is an eye condition where theoptic nerve, which connects the eye to the brain,becomes damaged. It can lead to loss of vision if not detected and treated early on. The training for AHPs to become glaucoma specialists comprised of an in-house training course delivered to a national standard, and one module at doctorate level delivered by a local university. Staff gave us a copy of the in-house training programme, which covered anatomy, visual acuity testing, visual field assessment, an overview of glaucoma and specific variations of the condition, visual field defects, and a number of common eye defects.
- Glaucoma specialist practitioners ran clinics for patients whose glaucoma was stable, to relieve doctors' workload. The clinics ran alongside those conducted by doctors, which meant any patients whose condition was found to be unstable could be referred to and seen by a doctor on the same day.
- BMEC staff participated in 'quality improvement half days' (QIHD). QIHDs were half-day training sessions held each month, except September and October. No elective work took place in the centre during QIHDs. Attendance records were held centrally by the trust. Staff we spoke with were very positive about the QIHDs, and told us they were interesting and helped them to improve the quality of their patient care.
- We spoke with a nurse educator in the BMEC outpatients department, who showed us training and induction programmes for healthcare assistants and registered nurses working there. All staff were given an introduction to ophthalmology and the centre, including a tour of the centre followed by a programmed of lectures and practical training, and training on the centre's IT systems. Registered nurses were given workbooks on four key areas of ophthalmology knowledge. Registered nurses also had a period of between four to six weeks of mentoring, during which they completed their workbooks, and training on pre-operative assessment procedures.

- At the end of their mentoring period, nurses completed a written theory test to assess their knowledge and ongoing learning and support needs. We were shown copies of the induction programmes for both staff groups.
- On starting work in BMEC, nurses were issued with a competency record book in which they were expected to provide evidence of their proficiency in areas specific to ophthalmology. Staff completed the programme of in-house competencies while waiting for a place on the formal ophthalmology course. The local university delivered the course which had two modules at level 6 via a distance learning course. We saw a copy of the competency record, which included trust wide information, key skills and areas of ophthalmology-specific knowledge.
- The BMEC nurse educator kept nurses' and healthcare assistants' training and education records secure in a locked filing cabinet. We saw each nurse and healthcare assistant had an individual learning and development file, in which records of all training and reflective practice they completed were kept. As well as the master copy held by the nurse educator, each member of staff held their own copy of the document.
- The BMEC nurse educator planned and facilitated a week-long series of lectures for student nurses, during their rotation into the centre. Staff showed us a copy of the lecture programme, which included sessions on eye anatomy and physiology, cataracts, glaucoma, retinal detachment, visual acuity, intraocular pressure, equipment and instruments used in ophthalmology, and common abbreviations and terminology.
- The BMEC nurse educator actively supported nurses through their revalidation with the Nursing and Midwifery Council. They delivered a training session on the process during one of the centre's QIHDs, and staff showed us their 'revalidation folder'. The folder contained guidance on how to go through the revalidation process, the trust's standard operating procedure for revalidation, evidence gathering, acting as a confirmer and a checklist of requirements and examples of appropriate supporting evidence. The nurse educator showed us their electronic records of all nurses' revalidation dates. They told us they emailed every nurse six months before their revalidation due date with a checklist to complete for the process, and arranged a meeting with them to pre-assess their portfolio and supporting evidence.
- BMEC was the ophthalmology teaching centre for the medical school of a local university, and provided both undergraduate and postgraduate training for its students. Training and education included an understanding of the causes, effects on patients and treatment for Behçet's syndrome.

Multidisciplinary working

For City Hospital Outpatients and Diagnostic Imaging:

- The outpatients and diagnostic imaging departments supported multiple speciality clinics. All staff we spoke with told us the staff within the hospital and across the trust worked effectively together and that there was good communication.
- In most departments clinical nurse specialists held clinics.
- Staff attended multidisciplinary team meetings on a weekly basis. Staff told us everyone's contributions were valued during these meetings and that they worked effectively.
- We spoke with staff in the cardiology department who showed evidence of MDT meetings involving consultants, the practice manager, nurses, ambulatory care and echocardiogram staff.
- We spoke with patients who gave positive feedback about the way different departments worked together.
- The imaging department had developed good working relationships with other local hospitals. Systems were in place to share electronic images with relevant professionals that were treating patients. This helped to prevent any errors for the patient's future treatment as all of the information would be available. There were systems in place ensure diagnostic imaging reports were available to referrers, clinicians, wards and the patients GP. Staff told us that they flagged unexpected findings such as an aortic aneurysm or deep vein thrombosis to the referrer, the multidisciplinary team co coordinator and the specialist clinician. Staff also sent reports to GP's and uploaded them onto an electronic system, this enabled GP's who did not have a direct electronic link to access patients' reports. The department had specific reporting codes which triggered such alerts

For Birmingham and Midland Eye Centre (BMEC):

- Staff in the BMEC orthoptics department told us they had close liaison with consultants in the eye and main

hospital EDs, as a number of systemic conditions, such as acute strokes, could initially present as eye problems. When staff in BMEC identified potential serious conditions through eye examinations, they referred patients to the appropriate ED as an emergency.

- On average, BMEC outpatients had eight to 10 referrals a day from the centre's emergency department, for ultrasound examination of patients with potential retinal detachments, as that condition can mask a tumour. If staff identified a new tumour the department immediately referred the patient to the specialist ocular oncology service at another NHS trust.
- Staff told us BMEC outpatients had a close working relationship with a charity in Birmingham who provided support for people living with impaired vision or total sight loss, helping patients to have training on using computers.
- BMEC had a service-level agreement with a neighbouring NHS trust, who supplied one neuro-ophthalmology consultant clinic session every week, and two each fifth week.

Seven-day services

For City Hospital Outpatients and Diagnostic Imaging:

- Some outpatient clinics had extended working days to help reduce waiting lists and would work until 8pm.
- There were no outpatient clinics held at weekends at City Hospital.
- The diagnostic imaging department was available seven days per week to cover all modalities. Staff were able to conduct MRI scans between 8am and 8pm seven days per week. There was a mobile MRI scanner to accommodate workload.
- CT scanning and cardiac scanning was available 24 hours per day, seven days per week.
- We saw there was a standard operating procedure in place for the transfer of radiological examinations out of hours.
- Ultrasound scanning was available for inpatients at weekends.
- The trust was part of the Black Country Alliance, a partnership between three NHS trusts with the aim to improve health outcomes and maximise resources available. This provided additional resource for radiology across the area.

For Birmingham and Midland Eye Centre (BMEC):

- BMEC outpatients was normally open from 8.30am to 7pm, Monday to Friday. BMEC provided additional clinics during some evenings and weekends if demand meant they were necessary.

Access to information

For City Hospital Outpatients and Diagnostic Imaging:

- All staff had access to policies, procedures and guidance through the hospital intranet. We saw that staff could easily access the systems although they told us there were often IT issues which could make this difficult.
- Staff across divisions could access radiology images through the Picture Archiving and Communication System (PACS).
- Staff told us and we saw that information was shared with them verbally by managers and also electronically through emails and newsletters.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC):

- Staff we spoke with had a good understanding of the Mental Capacity Act 2005 and how patient's ability to understand and consent to care and treatment may change.
- Staff told us, and we saw the trust's standard consent form included a section on mental capacity assessment.
- Staff showed understanding of the deprivation of liberty safeguard process but told us they had not had experience of using this.
- Doctors, nurses and allied health professionals all demonstrated a good understanding of consent, and we observed numerous instances staff obtaining patients' consent before any examination or treatment took place.

Are outpatient and diagnostic imaging services caring?

Good

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC):

We rated caring as good because:

- We saw staff interacted respectfully and politely with patients and those attending with them.
- We saw staff fully explained the process for assessment, examination and diagnosis and treatment in a clear way for the patient to understand. Patients we spoke with told us they had felt fully involved throughout their consultations and treatment.
- We saw staff provided emotional support for patients and showed understanding of their anxieties.
- BMEC employed an eye clinic liaison officer (ECLO), who was registered blind who provided support and was highly regarded by patients we spoke with.

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Compassionate care

For City Hospital Outpatients and Diagnostic Imaging:

- During the inspection we saw staff interact respectfully and politely with patients and those attending with them.
- We observed staff introduced themselves and checked the names of patients at the initial meeting.
- We saw staff took the time to assist patients when required and quickly built rapport with them by making friendly conversation.
- We spoke with 11 patients, family members and carers. Those we spoke with told us the staff were always polite, helpful and caring.
- We reviewed the results of the Friends and Family Test (FFT) for the OPD across the trust. Between March 2016 and February 2017 88% of patients who completed the survey said they would recommend the service to their friends and family.

For Birmingham and Midland Eye Centre (BMEC):

- We saw two receptionists in BMEC outpatients looking after patients who were having difficulty using self-check-in kiosks. The receptionists were polite, cheerful and friendly, and efficiently resolved the patients' problems.
- One patient at BMEC told us staff at the centre were "always very good", introduced themselves, explained what they were doing and ensured the patient was comfortable during any procedure.
- One patient told us the staff in BMEC outpatients all listened to any concerns they had, no matter how busy the staff were. The patient told us staff always responded to any issues they saw patients experiencing, and did not wait for patients to have to ask for help.
- Patients described staff in BMEC outpatients as "kind", "courteous" and "caring".

Understanding and involvement of patients and those close to them

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC):

- We saw staff fully explained the process for assessment, examination and diagnosis and treatment in a clear way for the patient to understand. We observed a registrar ensured a patient was satisfied with the ongoing treatment plan and discussed the options available for future appointments.
- Patients told us they were fully involved with consultations with medical and nursing staff and had felt they had received all of the information required about their diagnosis and treatment.
- We saw staff involved those attending with them where appropriate to ensure the patient had support following the consultation.

Emotional support

For City Hospital Outpatients and Diagnostic Imaging:

- We saw staff provided emotional support for patients during the inspection. We observed a patient's pre-operative assessment where staff reassured the patient and showed understanding of the patient's needs with regards to their family.
- Staff we spoke with showed understanding of the anxieties patients may have when attending the department. Staff told us they always took the time to provide emotional support for patients who required it.

For Birmingham and Midland Eye Centre (BMEC):

- BMEC employed an eye clinic liaison officer (ECLO), who was registered blind. The ECLO had started out as a volunteer but had been in post in a paid role, funded by a local charity for people living with sight loss, for two years. The ECLO provided emotional and practical support for patients living with and newly diagnosed

with impaired vision, including attending initial appointments and carrying out home visits. Provision of an ECLO is recommended by the Royal National Institute for the Blind.
- One patient described the BMEC ECLO as "outstanding", and told us they had given them more help than they had ever experienced before from a healthcare provider.

Are outpatient and diagnostic imaging services responsive?

Good

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC):

We rated responsive as good because:

- Extra breast clinics took place throughout the day and during the evenings to meet the demand of services and to reduce waiting times for patients.
- The BMEC waiting area and processes for appointments had certain adaptions in place to meet the needs of patients using this specialist building. This included colour coded waiting areas, one-stop clinics, induction loops for the hearing impaired and a designated car park.
- Staff we spoke with were clear of the complaints process and there were good links with the Patient Advocacy and Liaison Service.

However:

- Aside from the cardiology clinic waiting area, there were no patient information leaflets for how to raise concerns about the service.
- Staff told us that clinics often went over the scheduled time and patients could therefore be waiting longer than expected.

Service planning and delivery to meet the needs of local people

For City Hospital Outpatients and Diagnostic Imaging:

- The trust held specialist outpatient clinics within main outpatients including respiratory and cardiology.
- The breast unit offered a 'one stop' service. We saw patients attend for consultation, ultrasound scan, further consultation and diagnosis. Staff told us that the service would also provide patients with treatment when necessary. Extra clinics took place throughout the day and during the evenings to meet the demand of services and to reduce waiting times for patients.
- Managers told us that the hospital facilitated some telephone appointments and virtual clinics. A virtual clinic is a planned contact by a healthcare professional for the purpose of clinical consultation, advice and planning.
- Data provided by the trust showed that between November 2015 and October 2016 the 'did not attend' (DNA) rate for City Hospital was 7%.This was lower than the England average of 10%. At the time of the inspection there had been no audits conducted concerning patients not attending their appointment.
- Patients we spoke with told us that if they had required a different time or date for an appointment the service had been flexible to meet their needs.
- Staff and patients told us that the car park could be busy at times however did not generally cause too many issues. Patients attending the oncology department for chemotherapy did not need to pay for the car park.
- There was sufficient seating and toilets for patients attending the outpatients and diagnostic imaging departments.
- We saw that volunteers were available to assist patients to the correct waiting area and that there was clear signage. However, staff told us that volunteers were not available every day and patients were often confused about which waiting area they should be attending.

For Birmingham and Midland Eye Centre (BMEC):

- BMEC had its own car park, directly outside the building, and a 'drop off' point at the main entrance. This meant people living with impaired vision did not have to walk far, across unfamiliar territory, to attend appointments.
- Direction signs in BMEC used large black lettering on a yellow background. This combination was easier to read for people living with partial sight.
- The waiting area in BMEC was well-lit and had sufficient seating for patients and their friends, carers or relatives.
- The waiting area for patients outside pharmacy did not protect patients' confidentiality, because there was nowhere for patients to wait apart from by the pharmacy hatch and those waiting could overhear conversations between pharmacy staff and patients being attended to.

- The consulting rooms in the BMEC orthoptics department were large, and two or three patients underwent consultations at the same time, only separated by screens. Patients were able to overhear conversations between staff and other patients in the room. Staff told us they were not able to protect patients' dignity and privacy due to the way the rooms were set up, but they had one single room they were able to use if patients expressed concern. We asked staff if they told patients about this facility and if staff offered it to patients for their consultation. Staff told us that the patients only used the room if they raised the issue.

Access and flow

For City Hospital Outpatients and Diagnostic Imaging:

- Data provided by the trust showed that between January 2016 and December 2016 the trust's referral to treatment time (RTT) for non-admitted pathways was worse than the England overall performance and on a downward trend. The figures for December 2016 showed 88% of this group of patients were treated within 18 weeks versus the England average of 90%.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral with symptoms of cancer with an average of 95%.
- The trust was performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis. The percentage across the trust between January 2016 and December 2016 was 98%.
- Between January 2016 and December 2016 the percentage of patients across the trust waiting more than six weeks to have a diagnostic test carried out was lower than the England average.
- Hospital data showed that effective systems had been put into place to improve referral to reporting times of diagnostic procedures such as computed tomography (CT), magnetic resonance imaging (MRI) and Ultrasound (USS). For example In January 2017 the trusts pledge of referral/scan to report times being less than 14 days was achieved in 33% of cases in plain film (PF), 83% in MRI and 62% in CT. In February 2017, this had improved significantly when referral/scan to report times of less than 14 days increased to 91% in PF, 98% in MRI and 90% in CT. Scanner capacity, availability of a sub specialist radiologist to report on scans , the timeliness of the scan relative to the target date were the reasons the hospital were still not meeting the 100% target all of the time.
- There was an electronic system in place for patients to use to check in to the department. Patients used computer screens at the main reception area which registered their arrival and displayed information of where they should wait for their appointment. Staff told us patients were often confused about where to go for their appointments and found the system difficult to use. We spoke to patients and noted mixed opinions about using the electronic system.
- There were no chaperone notices in the outpatient department. Staff told us this service was always available for patients who requested it. They told us that if a patient was undergoing an intimate examination they would always ensure there was a chaperone present. However, staff had concerns that there were not always enough staff to cover if two patients required a chaperone at the same time and so would have to delay the appointment for one patient if this were the case.
- We saw that some clinics were over running and staff told us this often occurred and could be regularly up to two hours over the scheduled times. An audit had been conducted and showed that specific clinics seemed to regularly run over time. Analysis of the results led to a registrar also seeing patients during these clinics and reorganisation of the times patients were booked in. The changes had been effective and staff reported clinics finishing, on average, one and a half hours earlier.
- All of the patients we spoke with told us they were satisfied with the time they had waited for their appointments during the inspection. One family member told us that a previous appointment had required them to wait over an hour which had seemed like a long time as they were attending with a child.
- Staff told us that due to the reduction in RGNs there were certain procedures that patients may be required to wait for until a nurse was available such as application of dressings.
- Aside from cardiology, there were no reception staff based at any of the outpatient clinic areas. Staff and patients told us this caused confusion and it could be

difficult for information to be gained. Staff told us this had resulted in patient's waiting at the wrong areas and frustration about waiting times as they were unable to be updated regularly.
- Electronic screens were in place in waiting areas however these were not in use during the inspection.
- Data provided by the trust showed that between September 2016 and March 2017 the imaging department met targets for the turnaround of images from Magnetic Resonance Imaging (MRI) computed tomography, non-obstetric ultrasound and DEXA scan by over 99% each month.
- All urgent and in patient radiology requests were prioritised and reported within 24 hours.
- The assistance service manager of the radiology department produced a daily report to keep track of the workload and ensure that waiting times were minimised. If necessary, this would involve outsourcing work to an outside company. The reports were published so the whole team were aware of the current situation with workload. This was also discussed during departmental 'red to green' meetings so that all hospital areas were aware of the capacity for radiology.

For Birmingham and Midland Eye Centre (BMEC):

- BMEC hosted the Birmingham Behçet's Syndrome National Centre of Excellence, as a specialist clinic which allowed people living with Behçet's syndrome to be seen by consultants from different specialties on the same day, rather than having to attend different appointments. The centre is one of only three in the country. Behçet's syndrome is a rare, chronic auto-inflammatory multisystem disorder of unknown cause.
- We saw data evidencing from October 2016 to March 2017, BMEC had performed better than the NHS's 92% target for referral-to-treatment times of 18 weeks or less. BMEC managers told us patients normally waited between six and 10 weeks for their first appointment.
- However, managers told us the department had a backlog of over 24,000 patients who were overdue for follow-up appointments. While no specific data was available, we were told this was not an unusually high figure compared to other NHS ophthalmology departments. Patients in this backlog had already attended BMEC for one or more consultations, and had been referred for follow-up assessments a number of weeks or months later, however they had not had the follow-up appointment within the time specified at the initial consultation. The backlog appeared on the department's risk register, and was graded as 'high'. Actions to mitigate the risk were listed, and senior managers told us these were regularly undertaken. Senior managers told us every patient on the list had been individually risk assessed by a manager working with the centre's consultants, and the list was reviewed monthly. BMEC were working with community optometrists and putting on extra clinics, three Saturdays per month and two evenings per week, to reduce the backlog. Staff had not reported any serious incidents amongst patients who were overdue for follow-up appointments.
- BMEC technicians ran 'virtual clinics' for low-risk patients, carrying out assessments and screening checks without a doctor present. Data from the assessments was reviewed by a consultant, and if anomalies were identified the patient was asked to attend the centre for a face-to-face consultation. This process complied with the Royal College of Ophthalmologists 'Ophthalmic Services Guidelines - Ophthalmic Imaging, November 2016'.
- In 2016/17, BMEC handled over 166,003 outpatients appointments.
- Many patients attending BMEC needed to visit two or more different sections of the outpatients department for different tests and consultations. Staff told us, and we saw details of multiple appointments were all contained in one letter to the patient, rather than separate letters for each appointment. As well as being more cost-efficient, this was simpler for patients to understand and ensured patients' appointments did not clash or overlap. Staff told us they aimed to provide a 'one stop' service for patients, rather than them having to make multiple journeys to the centre.
- Band 5 ophthalmic technicians in BMEC ran clinics for patients living with ocular hypertension or glaucoma, provided the condition was very stable. Patients underwent optical coherence tomography scans, visual fields tests, intraocular pressure assessments, a review of their medicines and visual acuity tests. Provided no abnormalities were found, against national standards, outcomes were sent to one of the centre's doctors to review, and reported to the patient and their GP by letter. This meant only patients whose conditions had changed needed to see a doctor.

- Senior managers told us they were aware of problems with availability of patients' notes for clinics, and that clinics had had to be cancelled because of this. However, the trust told us no clinics had been cancelled for this reason from April 2016 to March 2017.
- On arrival in the BMEC outpatients' department, signs directed patients to use one of three touch-screen self-check-in kiosks. A staffed reception desk was adjacent to the kiosks, in case patients or their escorts had difficulty with the kiosks, or preferred not to use them. The receptionist had access to the same check-in system and was able to book patients in for their appointments.
- Staff told us, and we saw patients' BMEC orthoptics appointment letters informed them they were likely to be in the department for up to three hours. This allowed patients to plan parking or other transport. Staff told patients about any delays in appointments when they booked in at the reception desk, and updated them if clinics started to run late.
- However, there was no display of waiting times or information on late-running clinics in the main BMEC outpatients waiting area. The department had a number of wall-mounted screens; however during our visit only one of these was switched on, and was showing a television programme.
- BMEC had its own specialist pharmacy to dispense medicines for eye conditions. The pharmacy was closed from 1pm-2pm and we saw several patients waiting for medicines during this time.

Meeting people's individual needs

For City Hospital Outpatients and Diagnostic Imaging:

- Staff told us and we saw that translation services were available and regularly used when a patient's first language was not English or if they had a hearing impairment. Telephone services were accessible but staff told us that usually a face-to-face interpreter attended appointments with patients.
- We saw that wheelchair access was good in all areas of the department.
- Staff we spoke with were aware of the specific needs of patients with dementia however told us they were not aware of any training available to help them work most effectively to meet the needs of such patients. Staff told us that usually patients with dementia attended with a carer so they would seek guidance from them for anything specific that may help the patient with their care and treatment.
- Staff were unaware of any processes in place for patients who had a learning disability. They told us they had not received any formal training or access to any additional tools to assist with communication. Staff told us that as patients living with a learning disability would usually attend with a carer they would ask for the carer for guidance for how to help meet the needs of the patient. Staff were unaware of any alert system to identify patients who needed extra support.
- Bariatric equipment was available for patients whose weight was over the recommended limit for standard equipment. Staff told us they could access equipment such as hoists, chairs and beds from the wards.
- We saw patient information leaflets available in areas across the outpatients and diagnostic imaging departments. These covered relevant issues depending on the department they were located in.
- We saw coffee machines available in areas where patients may be there for longer periods of time such as the breast care unit and oncology department.

For Birmingham and Midland Eye Centre (BMEC):

- Waiting areas in BMEC outpatients used different coloured seats for different consulting areas. On booking in, patients were directed to sit in chairs of a colour appropriate to their clinic.
- All the reception desks in BMEC had induction loop systems for people who used hearing aids, and had low-level sections for patients who used wheelchairs. However, there were no signs informing patients that induction loop systems were available.
- Slit lamps are instruments consisting of a high-intensity light source that can be focused to shine a thin sheet of light into the eye. They are used to look for any diseases or abnormalities in the anterior (front) portion of the eye, including the eyelids, lashes, lens, conjunctiva, cornea, and iris. BMEC had portable slit lamps and intraocular pressure check machines, used during assessment of patients' eyes, which staff could take to bariatric patients in the eye ward if they could not access the department for appointments. All of the slit lamp stations in BMEC were designed to be accessible for patients who used wheelchairs.

- In line with guidance from charities supporting people living with impaired vision, and the government's Office for Disability Issues, signs displayed in the BMEC outpatients' department and screens on the self-check-in kiosks used large black text on a yellow background. Appointment letters for BMEC outpatients also used large black print on yellow paper, if sent to patients living with impaired vision. Research has shown this colour combination to be the easiest to read for people living with impaired vision.
- The department had eye drop dispensers which were designed for patients who had poor dexterity, if they were required.
- Signs directing patients to outpatients' reception from the main entrance to BMEC were clear and also used large back text on a yellow background.
- The first screen displayed on BMEC outpatients' department's self-check-in kiosks displayed a large, clear selection of national flags for patients to choose the language they understood. Patients then had a choice of entering their personal information, or scanning the barcode on their appointment letter, to register their arrival in the department.
- Hospital volunteers worked in the BMEC outpatients department to assist any patients who needed help. However, a patient told us there were not many volunteers in the department compared to other areas of the hospital, despite it being an ideal place for them to work, with many patients who needed assistance.
- We saw the coffee shop area in BMEC outpatients was cluttered with tables and chairs, and it was impossible to move between them in a wheelchair. We saw several patients who used wheelchairs in the area, who were only able to use tables closest to the counter because of the spacing. Patients who were walking unaided also had difficulty moving between the tables for the same reason.
- A patient who used a wheelchair told us they had complained to BMEC about doors and fixed seating which made manoeuvring difficult. They told us the centre had responded quickly and made changes to ensure people who used wheelchairs were able to move around the department with as little difficulty as possible.
- All departments within BMEC outpatients had toilets accessible for a disabled person.

Learning from complaints and concerns

For City Hospital Outpatients and Diagnostic Imaging:

- We saw patient information leaflets regarding how to make a complaint available in the cardiology clinic but not in any other area of outpatients during the inspection. Staff told us they could print this information if a patient requested it.
- Staff we spoke with were aware of the complaints procedure and how to advise patients of this.
- Staff told us they would provide the details for the Patient Advice and Liaison Service (PALS) which was located in the same building as the outpatients department if a patient remained dissatisfied following them trying to resolve concerns at the time.
- Between March 2016 and December 2016 there were three formal complaints received in relation to the outpatients department and also three for the diagnostic imaging department. We saw that staff learnt from complaints and had put changes into place as a result of this. For example, one complaint was in relation to a student being present during an examination and so the department put up posters to inform patients that students would be present and to inform staff if they had concerns about this.
- We saw from meeting minutes and staff told us that learning points from complaints and concerns were discussed by senior staff during meetings including the quality improvement half days (QIHDs).

For Birmingham and Midland Eye Centre (BMEC):

- From January to December 2016, 96 complaints had been received about outpatients services at BMEC, which represented less than a tenth of one per cent of the appointments completed in the centre. Of those, 26 had been graded as 'low' level, 60 as 'medium' and 10 as 'high'. Thirty-four of the complaints had been upheld, 37 partially upheld and 25 not upheld.
- The majority of complaints made about BMEC outpatients services related to waiting times and cancellation of appointments. Twenty-six complaints involved patients expressing dissatisfaction with the treatment they had received, however only 14 of those had been upheld or partially upheld after investigation.
- Of the complaints graded 'high', only one had been upheld. The complaint involved a procedure resulting in temporary, avoidable harm to the patient. We were shown the original complaint and the trust's response to

the complainant. The trust had admitted it was at fault, apologised to the patient and given them details of what action had been taken to minimise the risk of the error reoccurring.

Are outpatient and diagnostic imaging services well-led?

Good

For City Hospital Outpatients and Diagnostic Imaging and Birmingham and Midland Eye Centre (BMEC):

We rated well-led as good because:

- Staff told us that their local managers were supportive and worked with them towards improving care for patients. All of the staff we spoke with told us they felt they could raise issues with senior staff if they needed to.
- Staff we spoke with were clear of the values of the trust and displayed the behaviours outlined in the nine 'promises' set.
- There were systems in place to enable department managers to identify and respond to issues affecting the service. All staff we spoke with told us they knew the process for raising concerns.
- Staff we spoke with told us that they were aware that the OPD and diagnostic imaging departments were listened to at a senior management level and they received communication with regards to current issues.
- BMEC was the only eye hospital in England offering ultrasound biomicroscopy service for glaucoma.
- BMEC was part of a gene therapy project, working with Oxford Eye Hospital to restore some vision to patients living with choroideremia, a rare form of genetic blindness.

However:

- There had been a workforce review of staffing for the service which had led to significant changes in the two years prior to the inspection. Staff told us they had not felt part of this and that they felt unaware of the strategy for the future of the service.
- Staff told us they did not think the executive team had a good insight into the everyday pressures of working within the outpatient department.

Leadership of service

For City Hospital Outpatients and Diagnostic Imaging:

- Staff told us that their local managers were supportive and worked with them towards improving care for patients. All of the staff we spoke with told us they felt they could raise issues with senior staff if they needed to.
- We saw good interactions between staff of all disciplines and all staff told us that senior managers were approachable and visible.
- The group directors for the outpatient and imaging services had both been in post for less than six months. Staff were positive about the changes they had made in this time and told us they were optimistic about the future of services under their leadership.
- Leaders could recognise the challenges to good quality care and how they could address this. For example, one leader told us there had been issues with recruitment so they had used social media and open days to assist in attracting new staff. Leaders also recognised that staff in the outpatients department had very little training in information technology (IT) so were looking to appoint IT literate staff to act as champions within the department.
- Staff told us they did not think the executive team had a good insight into the everyday pressures of working within the outpatient department.
- Senior managers told us they felt the executive team supported them well and felt that if they raised issues the team would manage them appropriately.
- Staff told us they watched the Chief Executive of the trust's weekly video brief and found this to be informative and useful.

For Birmingham and Midland Eye Centre (BMEC):

- A general manager, a lead nurse and a clinical director who reported to the trust's surgical services directorate management team managed BMEC.
- Each department within BMEC outpatients had a head of and deputy head of department.
- A band 7 service manager, four heads of departments and a team of patient access managers reported to the BMEC general manager.
- Senior managers in BMEC told us the centre was recognised nationally, for its specialised work as a tertiary referral centre, but they felt their own trust did not realise what they did, and said there as a knowledge

gap among senior executives. They gave us examples of poor communication from trust executives about changes to their services and structure, and told us they did not feel the trust executives valued the work done in BMEC. They told us the centre provided 20% of the trust's activity with less than 7% of its funding.

- Staff in BMEC told us they saw the centre's senior managers almost every day, and said they were approachable and supportive. They told us senior managers were happy to be contacted by email or text message out of hours and responded to urgent messages quickly. Staff described the BMEC lead nurse as a "go-to person". However, staff also told us they very rarely saw any of the trust's executive team in the centre.

Vision and strategy for this service

For City Hospital Outpatients and Diagnostic Imaging:

- Staff we spoke with were clear of the values of the trust and displayed the behaviours outlined in the nine 'promises' set.
- Staff were unaware of the vision of the service and told us they did not feel part of this or fully informed about what changes may take place over the coming years. Staff told us they felt this was discussed at management level but not with the wider clinical staff group.
- There had been a workforce review of staffing for the service which had led to significant changes in the two years prior to the inspection. Staff told us they had not felt part of this and that they felt unaware of the strategy for the future of the service.

For Birmingham and Midland Eye Centre (BMEC):

- BMEC's vision was "To deliver a high quality locally, regionally and internationally acclaimed, research driven service for all ophthalmic specialties in the management of acute and chronic disease". Staff we spoke with understood the meaning behind this statement and identified with its sentiments.

Governance, risk management and quality measurement

For City Hospital Outpatients and Diagnostic Imaging:

- There were systems in place to enable department managers to identify and respond to issues affecting the service. All staff we spoke with told us they knew the process for raising concerns although were unsure of whether they would receive feedback from doing so.
- Staff we spoke with told us that they were aware that the OPD and diagnostic imaging departments were listened to at a senior management level and they received communication with regards to current issues.
- We saw that there was a 'year of the outpatients programme board' that met on a monthly basis. We reviewed the minutes from the meetings and saw that actions and outcomes were discussed and rag rated.
- The diagnostic imaging department had a well-established IRMER committee that met on a four monthly basis. The committee had both routine and ongoing work including training sessions for non-medical referrers, monitoring, analysing and reporting of radiation incidents and reviewing of IRMER procedures.
- Outpatient managers attended a clinical records design authority meeting (CRDA) on a monthly basis. We reviewed the minutes from January 2017 to March 2017 and found they contained topics such as healthcare records, policy and standard operating procedures, scanned notes quality assurance procedures in addition to QHID feedback.
- We saw that audits had been undertaken or were being developed in the outpatient and diagnostic imaging departments in areas such as availability of notes, resuscitation trolley checks, hand hygiene and the five steps to safer surgery checklists.
- We reviewed the departmental risk registers and saw that there no risks identified in relation to the outpatient department at City Hospital. Seven risks were included in relation to the diagnostic imaging departments at the trust. Risks included the reduced ability to provide an interventional radiology service because of difficulties in recruiting radiology consultants and risks that specialist ultrasound services may not be provided by the trust due to lack of trained sonographers. The risk registers had review dates, control measures, actions and were rag rated.
- During the inspection staff told us there had been issues with the escalator in the OPD including patient falls causing injury and near miss incidents. Staff told us they had completed incident forms and raised their concerns about the safety issues. We saw that mitigation had been put in place such as signage however; the escalator was not on the trust risk register.

- We saw minutes from radiation protection committee meetings that were held quarterly. The meetings covered topics such as risk management, incidents and updates to practice.

For Birmingham and Midland Eye Centre (BMEC):

- The general manager, lead nurse and clinical director of BMEC held weekly meetings to discuss incidents and complaints. Heads of BMEC departments also attended the last meeting of each month. We saw minutes of the meetings, which recorded discussions about infection prevention and control, staffing, service planning, audits, safety, finance and governance.
- BMEC managers held quarterly governance meetings, which fed into the surgical directorate governance meetings. We saw minutes of the meetings held in April, July and October 2016, and January 2017, which recorded discussions about capacity, community clinics, clinical effectiveness, risk management, complaints, incidents, risks, and patient feedback. The minutes also detailed discussions about how the department was performing on staff appraisals, mandatory training, and sickness.
- Minutes of the most recent governance meeting included a record of discussion about the never event which had occurred in BMEC in 2016. Staff we spoke with told us they had been made aware of the incident and actions needed to minimise the risk of it reoccurring by email and in team meetings.

Culture within the service

For City Hospital Outpatients and Diagnostic Imaging:

- Staff told us they felt the culture in their departments and across the trust was open and positive towards improving the care for patients. They were all proud of their work and the standard of care and treatment that patients received.
- We observed open communication within the outpatients and diagnostic imaging departments with staff of all grades and disciplines.
- Senior managers told us they were proud of the teams and the way in which staff managed their workload.
- There was a policy in place called 'being open following a patient safety incident' however we found that staff were unclear of their role with regards to the duty of candour.

For Birmingham and Midland Eye Centre (BMEC):

- Senior managers told us they were "incredibly proud" of BMEC's reputation as a centre of excellence, and of its passionate consultants and staff. They said maintaining and protecting this reputation through high-quality care was their priority.
- Staff in BMEC told us the centre's consultants loved to share their knowledge and help develop staff.
- Allied health professionals in BMEC outpatients described a 'positive staff ethos' in the centre. They said everyone was happy to help everyone else, and they had very good support from consultants.

Public engagement

For City Hospital Outpatients and Diagnostic Imaging and For Birmingham and Midland Eye Centre (BMEC):

- Every department within BMEC had photographs of its staff on display in the waiting area. The photographs included each staff member's name and their job role.
- BMEC used social media to promote its services and those of related organisations, and to engage with patients and other members of the public.
- Across the OPD we saw boards with displays titled "you said, we did" that contained examples of improvements made to the service as a result of patient feedback.
- The trust collected patient feedback through the 'friends and family test'. We saw boxes and leaflets for patients to complete across the departments during the inspection.
- Senior managers told us that patient focus groups took place and that the trust had sought patients' opinions about the new self-check in kiosks.

Staff engagement

For City Hospital Outpatients and Diagnostic Imaging:

- Staff told us they were encouraged to develop, train and maintain their professional registration where appropriate.
- Staff we spoke with had all had an appraisal and regular time with their line managers. They told us they were able to approach them for advice and guidance whenever they required it and felt well supported.
- We saw that staff had access to the trust computer systems and received emails and bulletins to update them with information.
- Some staff members had taken on the role to be lead for the service in specialisms such as wound care and

dressings and dementia care. These staff members had completed training at a local university in specific modules to increase their knowledge and were working on projects to involve the wider staff group.
- The group director for imaging had started a monthly newsletter to cascade information to staff. We spoke with staff who told us they found this to be useful.
- The imaging service had a suggestion scheme in place where staff could submit ideas for service improvements online fully anonymously. All requests or issues raised through this were discussed with the group management board and information was fed back to the team.

For Birmingham and Midland Eye Centre (BMEC):

- Senior managers in BMEC told us the trust's senior management team regularly proposed changes to the centre's outpatients department without consultation. They gave us an example of the trust's decision to close the eye ward, and told us this was despite it being the only regional service of its kind. BMEC staff had not been involved in the decision to close the ward, and were not informed it was being discussed until after it had been made. Senior staff had had to negotiate with the trust's board to keep the ward open, by reorganising other services within the centre.

Innovation, improvement and sustainability

For City Hospital Outpatients and Diagnostic Imaging:

- Radiology work conducted through The Black Country Alliance had been nominated for an innovation award.
- Staff working in the radiology department told us they were encouraged to bring new ideas for service improvement to the department.
- The imaging department had launched a seven day interventional radiology nephrostomy service becoming the first trust in the Black Country Alliance to do this.
- Radiology staff had devised specific courses which were available nationally and had been well attended. This has generated income for the department which funded additional software.

For Birmingham and Midland Eye Centre (BMEC):

- BMEC was the only eye hospital in England offering ultrasound biomicroscopy service for glaucoma.
- BMEC was part of a gene therapy project, working with Oxford Eye Hospital to restore some vision to patients living with choroideremia, a rare form of genetic blindness.
- Orthoptists in BMEC outpatients had devised a checklist, printed on stickers attached to patients' notes, showing a list of 'red flag' escalation triggers. The checklist had started as a training 'aide memoire' for junior staff, however it had been found to be effective and adopted for use by all staff. Staff told us its use had been audited and found to be 100%.
- BMEC was one of only three national centres of excellence for treatment of Behçet's syndrome.

Outstanding practice and areas for improvement

Outstanding practice

End Of Life Care:

- The palliative and end of life care service integrated coordination hub acted as one single point of access for patients and health professionals to coordinate end of life services for patients.
- The service provided access to care and treatment in both acute hospitals and in the community, seven days a week 24 hours a day.
- BMEC ran a specialised clinic for people living with Behçet's syndrome, a rare, chronic auto-inflammatory multisystem disorder of unknown cause. The clinic was a national centre of excellence of treatment of the condition.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

BMEC-Emergency Department

- Increase availability of specialist medical staff and anaesthetists to minimise the risk that children, particularly those younger than three years of age, who attended department receive timely and appropriate treatment.
- Robust policies and procedures are in place to manage the effective security of prescription forms at a local level.
- The storage of fluids are tamper proof, in line with Resuscitation Council guidelines.
- Patient records must meet standards for general medical record keeping by physicians in hospital practice.

Medicine:

- Ensure compliance with the Mental Capacity Act (2005) is documented.
- Ensure attendance at mandatory training is improved.
- Take steps to reduce delays in the patient journey and ensure people are able to access care and treatment in a timely way.
- Improve the consistency of multi-disciplinary processes and ensure the implementation of consultant led board and ward rounds.
- Ensure patients have access to translation services when required.
- Ensure governance structures are embedded and a structured approach is taken to the identification and management of organisational risk.

Surgery including BMEC:

- Ensure measures are in place to prevent further Never Events to protect patient's safety.
- BMEC mandatory training targets for all clinical staff are met and recorded.

CYP BMEC:

- Improve local governance and ensure risks to the service are escalated, recorded, acted upon and reviewed in a timely manner.
- Medical staffing meets needs of patients and the service.
- Review the storage of emergency drugs and equipment for children and young people
- Age appropriate facilities are provided with separation of adult and children waiting areas and treatment areas.
- Mandatory training targets are met and recorded including paediatric life support.
- A framework for staff to develop and demonstrate competencies to care for children is in place.
- The trust must measure and monitor outcomes in relation to children and young people.

OPD including BMEC:

- The trust must ensure resuscitation trolleys are locked and secured with tamperproof tags.

Outstanding practice and areas for improvement

- The trust must ensure patient notes are kept securely and confidentially.
- The trust must ensure sharps bins and clinical waste are stored securely and safely.
- The trust must ensure consulting rooms in BMEC protect patients' dignity and privacy, and prevent people from overhearing conversations between staff and patients.
- The trust must ensure there are improvements with staff completion of mandatory training.
- The trust must ensure all staff who carry out root cause analyses are trained to do so.
- The consulting rooms in the BMEC orthoptics department were large, and two or three patients underwent consultations at the same time, only separated by screens. Patients were able to overhear conversations between staff and other patients in the room. Staff told us they were not able to protect patients' dignity and privacy due to the way the rooms were set up, but they had one single room they were able to use if patients expressed concern. We asked staff if they told patients about this facility and if staff offered it to patients for their consultation; Staff told us that the patients only used the room if they raised the issue.

Action the hospital SHOULD take to improve

Urgent and Emergency care including BMEC:

- The trust should review cleaning schedules and include the windows above the minors' area, which were not part of the housekeeping schedule and had not been cleaned for several months.
- The trust should review action plans from national and local audits, in particular record keeping audits to improve the quality of patient records.
- The trust should improve the communication of waiting times to patients, especially if electronic displays are not in use.
- Look for ways to improve patient privacy in the department.
- Improve the waiting area and provision of age appropriate toys and games for children and young people in the department.
- Consider introducing an electronic flagging system for vulnerable patients, such as those living with dementia or a learning disability.
- Consider participating in a wider range local and national audits in order to assess, evaluate and improve care of patients in a systematic way
- Staff should routinely assess patients' pain on arrival to the department.
- Introduce a water dispenser in the BMEC ED waiting room to ensure vulnerable patients have quick access to water at all times.
- Implement SLA's with other trusts so that paediatric patients are kept safe at all times
- Improve communication from executive colleagues regarding changes being proposed to the department.

Medicine:

- Review the content of the emergency resuscitation trolleys and ensure security of the contents.

Surgery including BMEC:

- Safety thermometer information should be displayed on the wards. Staff members should be aware of their ward scores.
- Competencies for nursing staff working in surgical specialisms should be revisited after their initial competency 'sign off' stage.
- Patients should be consented for surgery prior to arrival on the ward
- Wider learning should be promoted through complaint trends being shared amongst all areas of the trust
- Ensure all BMEC staff are aware of the duty of candour and when this would be applied following a notifiable safety incident.
- Ensure all BMEC staff can identify a deteriorating patient; and that this is recorded in a structured way in order to monitor the effectiveness of this.
- BMEC service work towards minimising cancelled procedures due to lack of patient records.
- BMEC staff to be fully aware of when patients may require a deprivation of liberty safeguard (DOLS) application in order to ensure patients that lack capacity to consent to treatment is provided with appropriate care.

CYP BMEC:

- That a strategy for services for children and young people is developed and embedded, and there is improved reporting about service plans and priorities.

Outstanding practice and areas for improvement

- Review the arrangements for data collection that is specific to children and young people such as the audit plan and reporting, training and development records.
- Greater visibility and support of the children and young people service from the executive leadership team.

End Of Life care:

- The service must ensure they are preventing, detecting and controlling the spread of infections, including those that are health care associated in the mortuary department.
- The trust should ensure they have updated 'Anticipatory Medication Guidelines'. We could not be assured staff were following the most up-to-date guidelines.

OPD including BMEC:

- The trust should ensure staff working in the outpatients department have their competencies checked regularly and that this is evidenced.
- The trust should ensure that staff receive training to improve awareness of who the trust safeguarding leads are.
- The layout of the consulting rooms in the BMEC orthoptics department did not always ensure patient's privacy and dignity were protected.
- The trust should ensure all incidents are reported including those involving patient falls on the escalator in the Birmingham Treatment Centre.
- The trust should ensure patients in the BMEC outpatients waiting area are kept informed of waiting times and late-running clinics.
- The trust should reassess the layout of the BMEC coffee shop seating area to ensure people can move about safely, and sufficient space is provided for people using wheelchairs.
- The trust should ensure that all staff have an appraisal.
- The trust should ensure there are chaperone notices in the outpatient's department.
- The trust should ensure there is clear signage in the outpatient's department.
- The trust should ensure staff complete training to raise awareness and improve skills for working with people with learning disabilities.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (g) Emergency resuscitation trolleys were not all secure there were no security tags on the drawers to alert staff to tampering with the contents. Measures to prevent further Never Events had been implemented to protect patient's safety. These newly implemented actions must be maintained, monitored and reviewed. ensuring that persons providing care or treatment to service users have the qualifications, competence skills and experience to do so safely. The provider did not ensure that all staff were up to date with paediatric life support training. The provider did not ensure there was a framework for staff to develop and demonstrate competencies to care for children is in place. the proper and safe management of medicines; The registered provider did not ensure medication was stored appropriately and that resuscitation trolleys were fitted with tamper-proof seals. There were not enough specialist medical staff and anaesthetists in BMEC to minimise the risk that children, particularly those younger than three years of age, who attended the department received timely and appropriate treatment.

This section is primarily information for the provider

Requirement notices

Staff combined the resuscitation trolley for adults and paediatric patients. We found storage of fluids was not tamper proof in line with resuscitation council guidelines

The provider did not ensure there were enough specialist medical staff and anaesthetists to minimise the risk that children, particularly those younger than three years of age, who attended the department received either timely or appropriate treatment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15 (1) (c) Suitable for the purpose for which they are being used. The provider did not ensure there was an age appropriate facilities provided with separation of adult and children waiting areas and treatment areas.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Where risks were identified the provider did not introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. Not all assessments, triage records, management plan/ comments, observations and outcomes were fully completed for all patients.

This section is primarily information for the provider

Requirement notices

The provider did not ensure that Adult and Children Safeguarding information was properly recorded

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2)(a) HSCA 2008 (Regulated Activities) Regulations 2014 Not all BMEC staff were up to date with mandatory training and /or training was appropriately recorded.