University Hospitals Birmingham NHS Foundation Trust

Inspection report

Queen Elizabeth Hospital Birmingham
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Date of inspection visit: 24-26 April 2023, 11 May 2023, 18 May 2023, 13 June 2023 and 4 July 2023.
Date of publication: 14/02/2024

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

University Hospitals Birmingham NHS Foundation Trust is one of the largest teaching hospitals in England, serving a regional, national and international population.

In September 2016 the trust announced plans to merge with the Heart of England NHS Foundation Trust. The merger by acquistion took place on 1 April 2018. The combined organisation has a turnover of around £1.6 billion and provides acute and community services across a number of locations, however there are 4 main hospital locations:

- The Queen Elizabeth Hospital Birmingham
- Birmingham Heartland Hospital
- Good Hope Hospital
- Solihull Hospital

The trust also runs Birmingham Chest Clinic, a range of community services and a number of satellite units allowing people to be treated closer to home.

The trust has 2,366 in-patient beds across over 105 wards. In addition to this there are 115 children's beds and 145 day case beds. The trust operated over 7,100 outpatients and 300 community clinics per week.

The trust employs over 20,000 members of staff.

We carried out an unannounced inspection of the following acute services provided by the trust:

- Urgent and Emergency care at Queen Elizabeth Hospital Birmingham, Birmingham Heartlands Hospital and Good Hope Hospital because we had concerns about the quality of services,
- Neurosurgery at Queen Elizabeth Hospital Birmingham because we had concerns about the quality of services,

Our findings

- Cancer services (focused) at Queen Elizabeth Hospital Birmingham because we received information of concern about the service.
- The Section 29A Warning Notice was followed up in relation to the medical services at Good Hope Hospital.
- The Section 29A Warning Notice was followed up in relation to the maternity services at Birmingham Heartlands Hospital.

We were due to inspect the well-led key question however this was postponed due to the trust undergoing a well-led review by a partner organisation. This will now be completed later in the year allowing the trust the opportunity to implement any improvements and recommendations which were identified.

We did not inspect several services previously rated as requires improvement because this inspection was focused only on services where we had concerns or where significant concerns were previously identified and improvements were required. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

Our rating of services stayed the same. We rated them as requires improvement because:

• We rated 4 out of the 6 services we inspected as requires improvement and 2 as inadequate overall. We did not re-rate maternity.

• The well-led is the overall trust-wide rating, not an aggregation of services ratings. This therefore did not change from the good rating awarded in 2021.

• We have not taken the previous ratings of services at the Heart of England NHS Foundation Trust into account when aggregating the trust's overall rating. This is because we are still to inspect services at Birmingham Heartlands Hospital, Good Hope Hospital and Solihull and therefore we cannot include these ratings for the trust overall rating.

• Patients were not always protected from harm. There were serious concerns relating to safeguarding practices within the emergency departments. Services did not manage medicines well. Not all staff had received mandatory and safeguarding training, including training which became a legal requirement. Staffing remained a significant concern across the trust, especially within the medical services at Good Hope Hospital.

• Individual needs were not always met, the trust had still not implemented the Accessible Information Standard. People could not always access the service when they needed it or receive the right care promptly.

• Staff did not always feel respected, supported and valued. Leaders did not always run services well and did not always manage risk effectively. Governance systems were not always effective.

However:

• There had been some improvements identified within the maternity services at Birmingham Heartlands Hospital, women were being seen in a more timely manner by medical and midwifery staff.

• Service generally provided care and treatment based on national guidance and evidence-based practice. Staff monitored the effectiveness of care and treatment. The service made sure staff were competent for their roles. Staff worked together as a team to benefit patients. Key services were available to support patient care.

Our findings

• Staff predominantly treated patients with compassion and kindness. Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

How we carried out the inspection

We carried out this inspection on various days throughout April and May 2023. We also revisited the ED at Birmingham Heartlands Hospital in July 2023.

We visited areas relevant to each of the core services inspected and spoke with a number of patients and staff. On our inspections, there were teams of inspectors, including inspectors with specialisms in mental health and pharmacy, specialist advisors, operations managers and deputy directors.

During the inspection we visited 7 areas for cancer services at Queen Elizabeth Hospital Birmingham, 9 for medical services at Good Hope Hospital, 7 areas for neurosurgery services at Queen Elizabeth Hospital, 4 areas for urgent and emergency care at Good Hope Hospital, 5 areas for urgent and emergency care at Birmingham Heartlands Hospital and 3 areas for urgent and emergency care at Queen Elizabeth Hospital Birmingham.

We spoke with 167 staff members of various specialities and professions including (but not limited to) consultants, doctors, radiotherapists, matrons, nurses, midwives, midwifery and healthcare support workers, pharmacists, operating department practitioners, domestic staff and administrators.

We spoke with 66 patients throughout the departments and 20 relatives and carers. We also reviewed 75 patient records.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Use of resources

The use of resources was not inspected on this occasion.

Combined quality and resource

The combined quality and resources was not inspected on this occasion.

Outstanding practice

No outstanding practice was observed during the inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Our findings

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 29 legal requirements. This action related to 7 services.

Good Hope Hospital Medical Care

- The trust must ensure that the service has sufficient numbers of suitably qualified, competent, skilled and experienced staff to provide safe care and treatment to patients on all medical wards. (Regulation 18 (1) Staffing).
- The trust must ensure there is an effective risk and governance system in place to support safe, quality care. (Regulation 17 (1) Good governance).

Good Hope Urgent and Emergency Care

- The trust must ensure that all safeguarding training is up to date and in line with national guidance. (Regulation12(2)(c).
- The trust must ensure they consistently carry out daily safety checks of specialist equipment including equipment on resuscitation trolleys (Regulation(12)(2)(e)).
- The trust must ensure that safeguarding risk assessments for 16 to 17-year-olds are being completed. (Regulation 13(1)).
- The trust must ensure that they are monitoring and to ensure that opportunities to safeguard patients are not missed. (Regulation 13(2)).
- The trust must ensure that all mandatory training including learning disabilities and autism is up to date. (Regulation12(2)(c).
- The trust must ensure that the mental health room is meeting standards, relating to the alarm strip and for staff to know where this is located and staff support patients with mental health issues to use this room to be kept safe. (Regulation 12) (2)(a)
- The trust must ensure that all staff have regular appraisals. (Regulation (18)(2)(a).
- The trust must ensure that staff follow infection control procedures. (Regulation(12)(2)(e)
- The trust must ensure that they are compliant with facing the future standards for consultant provision in paediatrics department. (Regulation18(1)).
- The trust must ensure that there is the correct amount of skilled and trained staff to ensure all shifts are filled, to ensure care and treatment can be delivered. (Regulation 18(1)).
- The trust must ensure that they are compliant with the Accessible Information Standard. For example, ensuring communication aids are regularly checked and replenished to ensure that contents are available when needed. Also ensuring that interpreters are sought for patients who require the additional support with communication IE patients who have a hearing impairment. (Regulation (9)).

Our findings

- The trust must ensure there is a rapid tranquilisation policy in place. (Regulation (17)).

Birmingham Heartlands Hospital Urgent and Emergency Care

- The trust must ensure that all staff complete the mandated training including training which is a legal requirement. (Regulation 12 (1)).
- The trust must ensure all staff safeguard patients from the risk of abuse and improper treatment in a timely manner. (Regulation 13 (1)).
- The trust must ensure that they are monitoring and to ensure that opportunities to safeguard patients are not missed. (Regulation 13(2)).
- The trust must ensure that they are compliant with the Accessible Information Standard. For example, ensuring communication aids are regularly checked and replenished to ensure that contents are available when needed. (Regulation (9)).
- The trust must ensure all staff have a regular appraisal. (Regulation(18(2)(a)).
- The trust must ensure there is an effective risk and governance system in place to support safe, quality care. (Regulation 17 (1)).
- The trust must ensure there is a rapid tranquilisation policy in place. (Regulation (17)).
- The trust must ensure that staff assess and manage patients with sepsis in line with national evidence-based guidance and local policy. (Regulation 12 (1)).

Birmingham Heartlands Hospital Maternity Services

- The trust must ensure a standard operating procedure relating specifically to how the Pregnancy Assessment Emergency Room operates is in place to support the triage process. (Regulation 17 (1)).

Queen Elizabeth Hospital Birmingham Urgent and Emergency Care

- The trust must ensure that medicines are stored and managed safely. This includes ensuring resuscitation trolleys are tamper- evident and that it is clear how it is ensured that equipment and intravenous fluids required in an emergency are safe to use (Regulation 12(1)(2)(g)).
- The trust must ensure there are clear processes in place to identify, assess and record any individual risks including any individual risks identified in relation to the rails on patient trolleys and that this is clear within the trust policies and patient records. (Regulation 12(1)).
- The trust must ensure all mandatory training is up to date, including training around learning disability and autism and that it contains any essential modules (Regulation (12)(1)).
- The trust must ensure that staff follow infection control procedures (Regulation(12)(2)(h)).
- The trust must ensure they consistently carry out daily safety checks of specialist equipment including equipment on resuscitation trolleys (Regulation(12)(2)(e)).
- The trust must ensure all staff have a regular appraisal (Regulation(18(2)(a)).
- The trust must ensure that all patients have their hydration needs met and that there are clear processes in place that staff understand. (Regulation (14)(1)).

Our findings

- The trust must ensure that patients with a mental health need who have been identified as needing one to one care are not left alone if assessed as not safe to do so. (Regulation (12)(1)(2)(b)).
- The trust must ensure that they are compliant with the Accessible Information Standard. For example, ensuring communication aids are regularly checked and replenished to ensure that contents are available when needed. (Regulation (9)).
- The trust must ensure there is a rapid tranquilisation policy in place. (Regulation (17)).

Queen Elizabeth Hospital Birmingham Cancer Services

- The trust must ensure that systems and processes are in place, adhered to and monitored appropriately to minimise the impact of risks on people and avoid repeated never events and errors. (Regulation 17(2)(b).
- The trust must ensure all mandatory training is up to date, including safeguarding training and training around learning disability and autism and that it contains any essential modules (Regulation (12)(1)).
- The trust must ensure that there are sufficient suitably qualified, competent and skilled staff on each shift to ensure patients specific care needs are met. (Regulation 18 (1).
- The trust must ensure there is adequate suitably working equipment to provide diagnostic testing such as MRI scanning for patients which is accessible to meet the needs of patients using the service. (Regulation 15 (1)(f).

Queen Elizabeth Hospital Neurosurgery

- The service must ensure that it enables and supports everyone to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional in line with the mandatory Accessible Information Standard. Regulation 9(3)(c)
- The service must ensure all required training is up to date including safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards, and working with people with autism and learning disabilities. Regulation 12(2)(c)
- The service must ensure risk assessments are undertaken as per the trust policy and national guidance. Regulation 12(2)(a)
- The service must ensure staff complete medicines records accurately and keep them up to date in line with the Royal Pharmaceutical Society Professional Guidance on the administration of medicines in healthcare settings. 12(2)(g)
- The service must ensure that equipment necessary to meet people's needs including resuscitation equipment in theatre is both available and appropriately stocked, cleaned and monitored. Regulation 12(2)(f)
- The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of all regulated activity including a patient focused culture. Regulation 17(2)(a)
- The service must deploy enough suitably qualified, competent, skilled and experienced staff. Regulation 18(1)
- The service must ensure staff have access to appraisals in line with the trust policy. Regulation 18(1)

Action the trust SHOULD take to improve:

Good Hope Hospital Medical Care

- The trust should ensure staff treat patients with compassion and kindness and consider their dignity. (Regulation 10 (1)).

Our findings

- The trust should consider how they reflect the risks appropriately as escalated by staff.
- The trust should consider how they ensure all staff have the opportunity to report all incidents, so that there is an accurate oversight of risks and challenges.

Good Hope Urgent and Emergency Care

- The trust should consider privacy and dignity within the waiting room, and how navigators gain information. (Regulation 10 (1)).
- The trust should ensure all policies are up to date. (Regulation (17)(1)
- The trust should ensure that the mental health room meets the quality standards for Liaison Psychiatry services. (Regulation 15 (1) (c)).
- The trust should ensure all staff receive feedback from investigation of incidents. (Regulations 12(2)(b).
- The trust should ensure they continue their work to improve patient flow within the department. (Regulation (17)(1).
- The trust should consider training staff in delivering bad news to patients and families/carers. (Regulation12(2)(c).
- The trust should consider that staff have an understanding and knowledge of understanding patients with acute mental ill health. (Regulation 12(2)(a).
- The trust should consider, 'the trust should consider reviewing the quantity of equipment needed to undertake diagnostic tests within the department. (Regulation 15(3)(b)).
- The trust should consider an appropriate location to dispose of dirty water. (Regulation(12)(2)(e)

Birmingham Heartlands Hospital Urgent and Emergency Care

- The trust should ensure all staff receive feedback from investigation of incidents. (Regulations 12(2)(b).
- The trust should ensure intravenous fluids are stored safely and securely on all resuscitation trolleys. (Regulation 12 (2) (e)).
- The trust should ensure they continue to improve in their exercising of duty of candour. (Regulation 20 (2)).
- The trust should ensure all medicine are stored, managed and administered safely. (Regulation 12 (1) (2) (g)).
- The trust should ensure they continue their work to improve patient flow within the department. (Regulation (17)(1).
- The trust should ensure all areas within the department are risk assessed for ligature points and actions taken to mitigate the risks. (Regulation 12 (2) (a, b)).
- The trust should ensure patients are assessed for their pain and managed in a timely manner. (Regulation 12 (2) (a, b)).
- The trust should consider how all staff receive important information and updates within the department.
- The trust should consider how curtains within the department are managed and replaced to ensure they are not a risk to patients.

Birmingham Heartlands Hospital Maternity Services

- The trust should ensure that all triage records are completed accurately. (Regulation 17 (1) (2) (c)).

Our findings

- The trust should ensure that all risks within the service are identified, assessed and mitigated in a timely manner. (Regulation 17 (1) (2) (b)).
- The trust should ensure that all emergency equipment is checked regularly, so that this is safe and ready to use on women and birthing people. (Regulation 12 (1) (2) (e)).
- The trust should consider how to ensure confidentiality and discretion is maintained in the department at all times.
- The trust should continue to work on improving the breaches within the service to ensure women and birthing people receive a safe and effective service.

Queen Elizabeth Hospital Birmingham Urgent and Emergency Care

- The trust should ensure that all risks in relation to patients not being transferred onto a hospital bed after 6 hours are assessed, mitigated, and recorded. (Regulation 12(1)).
- The trust should ensure patients have their call bells if safe to do so. (Regulation 12 (1)).
- The trust should ensure that areas used for patients with a mental health need are assessed for any potential ligature points. (Regulation 12 (1)).
- The trust should ensure that all staff are knowledgeable around learning disability passports, this is me documents and that they are used when required. The trust should also ensure this is regularly monitored. (Regulation (9)).
- The trust should ensure that staff understand what is meant by duty of candour and how it applies to them (Regulation (17)).
- The trust should ensure that all staff have a good understanding understand of the Mental Capacity Act 2005 and the Mental Health Act 1983 and that they recognise the difference between the 2. (Regulation (17)).
- The trust should ensure that staff are able to quickly identify which staff on their shift have specific key skills and competencies such as being trained in tracheostomy and male catheterisation. (Regulation (12).
- The trust should ensure they continue their work to improve patient flow within the department (Regulation (17)(1).
- The provider should consider reviewing the effectiveness of its communications which encourages the community to attend non urgent appointments at an appropriate paediatric department. (Regulation (17)(1).

Queen Elizabeth Hospital Birmingham Cancer Services

- The trust should ensure that actions proposed following the culture review are completed and evaluated.
- The trust should ensure they monitor their short and long term strategy to increase capacity within the radiotherapy department.
- The trust consider should taking steps to ensure that the equality, diversity, and inclusion strategy is embedded within the culture.

Queen Elizabeth Hospital Neurosurgery

- The trust should ensure that staff within theatre adhere to appropriate infection prevention and control measure including surveillance for surgical site infections and the use of theatre hats. Regulation12(2)(h)

Our findings

- The service should ensure that delays in the ordering process of equipment does not affect the level of equipment available for use. Regulation 12(2)(f)
- The trust should ensure they try to rebook all cancellations within 28 days in line with national standards. Regulation 17(2)(b)
- The trust should continue to monitor and improve hand hygiene compliance.
- The trust should consider the implementation of a formal mentorship programme for newly appointed senior medical staff.

Is this organisation well-led?

The well-led inspection was postponed until later in the year.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Feb 2024	Good ➔➔ Feb 2024	Good ➔➔ Feb 2024	Requires Improvement ➔➔ Feb 2024	Good ➔➔ Feb 2024	Requires Improvement ➔➔ Feb 2024

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ➔➔ Feb 2024	Good ➔➔ Feb 2024	Good ➔➔ Feb 2024	Requires Improvement ➔➔ Feb 2024	Good ➔➔ Feb 2024	Requires Improvement ➔➔ Feb 2024

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Queen Elizabeth Hospital Birmingham	Requires Improvement ➔➔ Feb 2024	Good ➔➔ Feb 2024	Good ➔➔ Feb 2024	Requires Improvement ➔➔ Feb 2024	Good ➔➔ Feb 2024	Requires Improvement ➔➔ Feb 2024
Birmingham Heartlands Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Good Hope Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Solihull Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ➔➔ Feb 2024	Good ➔➔ Feb 2024	Good ➔➔ Feb 2024	Requires Improvement ➔➔ Feb 2024	Good ➔➔ Feb 2024	Requires Improvement ➔➔ Feb 2024

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Queen Elizabeth Hospital Birmingham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Feb 2021	Good Feb 2019	Good Feb 2019	Outstanding Feb 2019	Good Feb 2019	Good Feb 2019
Critical care	Good May 2015	Outstanding May 2015	Outstanding May 2015	Outstanding May 2015	Outstanding May 2015	Outstanding May 2015
End of life care	Good May 2015	Good May 2015	Good May 2015	Outstanding May 2015	Good May 2015	Good May 2015
Outpatients (sexual health services)	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015	Good May 2015
Surgery	Requires improvement Oct 2021	Good Oct 2021	Good Feb 2019	Good Feb 2019	Good Oct 2021	Good Oct 2021
Urgent and emergency services	Inadequate ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Good →← Feb 2024	Requires Improvement →← Feb 2024	Requires Improvement →← Feb 2024	Requires Improvement →← Feb 2024
Outpatients	Good Feb 2019	Not rated	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019
Cancer services	Requires Improvement ↓ Feb 2024	Good Oct 2021	Good Oct 2021	Requires improvement Oct 2021	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024
Neurosurgery	Requires Improvement Feb 2024	Requires Improvement Feb 2024	Good Feb 2024	Requires Improvement Feb 2024	Inadequate Feb 2024	Requires Improvement Feb 2024
Overall	Requires Improvement →← Feb 2024	Good →← Feb 2024	Good →← Feb 2024	Requires Improvement →← Feb 2024	Good →← Feb 2024	Requires Improvement →← Feb 2024

Rating for Birmingham Heartlands Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Apr 2023	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Apr 2023	Requires improvement Feb 2019
Maternity	Inadequate →← Feb 2024	Good Feb 2019	Good →← Feb 2024	Good Feb 2019	Inadequate →← Feb 2024	Inadequate →← Feb 2024
Surgery	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Requires improvement Feb 2019
Urgent and emergency services	Inadequate →← Feb 2024	Requires Improvement ↓ Feb 2024	Good ↑ Feb 2024	Requires Improvement ↑ Feb 2024	Requires Improvement →← Feb 2024	Requires Improvement ↑ Feb 2024
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Good Hope Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Inadequate →← Feb 2024	Requires improvement Apr 2023	Good →← Feb 2024	Requires improvement Apr 2023	Inadequate ↓ Feb 2024	Inadequate ↓ Feb 2024
Maternity	Requires improvement Jun 2023	Good Feb 2019	Good Feb 2019	Good Feb 2019	Inadequate Jun 2023	Requires improvement Jun 2023
Surgery	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Requires improvement Feb 2019
Urgent and emergency services	Inadequate ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement →← Feb 2024	Inadequate ↓ Feb 2024	Inadequate ↓ Feb 2024
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Solihull Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Maternity	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019
Surgery	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children and young people	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Requires improvement Feb 2019
Community end of life care	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Requires improvement Feb 2019
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Good Hope Hospital

Rectory Road
Sutton Coldfield
B75 7RR
Tel: 01214242000

Description of this hospital

Good Hope Hospital is operated by University Hospitals Birmingham NHS Foundation Trust. Good Hope Hospital predominantly serves the areas of Sutton Coldfield, North Birmingham and a large proportion of southeast Staffordshire. The catchment area is approximately 450,000 people.

Our inspection was focused on the medicine core service and Urgent and Emergency Care at Good Hope Hospital. The medical core service spans across 4 divisions at the trust (divisions 2, 3, 4, and 7) and the Urgent and Emergency Care was under division 2.

We carried out an unannounced focused inspection to follow up on the Section 29a Warning Notice which was issued following the full core service inspection of the medicine core service which we carried out in December 2022. We identified serious concerns within the staffing of the medical core service and gave the trust a notice to advise them that significant improvements were required. We gave the trust until 15 March 2023 to make these improvements.

We inspected Urgent and Emergency Care due to concerns which were raised. We identified serious concerns in relation to safeguarding knoweldge and practice.

At our last inspection in December 2022, we rated the medical core service as requires improvement overall, with inadequate in safe.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to the regulated activity; Treatment of disease, disorder or injury. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the medical wards at Good Hope Hospital as well as Urgent and Emergency Care.

Medical care (including older people's care)

Inadequate ↓

Is the service safe?

Inadequate →←

Our rating of safe stayed the same. We rated it as inadequate.

Assessing and responding to patient risk

Staff were not always able to implement measures to reduce the risk of harm to patients due to staffing restrictions.

Staff knew about specific risk issues. However, staff did not always follow care plans to mitigate risks due to low staff numbers and the high acuity of patients (how medically unwell the patients were). Across several wards, staff still told us that this had not improved since our last inspection where it was also found that staff did not have time to complete care plan actions to reduce or manage patient risk of harm. Staff gave examples of a high number of falls they had witnessed, many of which occurred due to not being able to always provide the close supervision many patients required. On Ward 8 we were informed of a recent incident where a patient had an unwitnessed fall having tried to mobilise independently to the bathroom. The patient had managed to pull the buzzer to alert staff to their incident, however, it took approximately 40 minutes for staff to attend due to staffing pressures. On Ward 24 staff told us of an incident where a patient had fallen that day due to staff not being able to provide the close supervision the patient was assessed as needing to prevent falls.

Staff also had concerns over patients who developed pressure damage due to staffing pressures preventing them from taking appropriate, preventative action.

We requested information after the inspection to review falls and pressure damage for all medical wards. However, the information we received did not identify how many incidents had occurred for each ward. The information did identify that there were challenges to staff completing the required risk assessments for patients when they were admitted for their potential falls risk and developing pressure damage.

Despite the concerns of most staff we spoke with, the ward manager for Ward 9 showed us their falls data for April 2023 whilst we were on site. For April 2023, there were 4 falls recorded on the ward compared to the 10 to 12 falls they had reported consistently for the previous months. This had been attributed to a rise in staffing for most shifts. Despite this being seen as a positive, it was acknowledged that this was the first time of recording lower falls and the month had not ended (meaning further falls could be recorded).

The service did not always meet the British Thoracic Society guidelines for patients being initiated on or receiving non-invasive ventilation. Non-invasive ventilation (NIV or 'mask ventilation') is a way of helping a person to breathe more deeply by blowing extra air into the lungs via a mask when they breathe in. The guidelines state as patients require level 2 care, this should be provided at an increased staffing ratio of 1:2 for at least the first 24 hours.

Patients who required NIV were allocated a bed on the respiratory ward (Ward 24).This ward had 6 beds allocated for patients requiring NIV in the Respiratory Acute Care Unit (RACU). This service was designed to be physiotherapy led with 2 nurses working alongside them who had completed additional competencies to care for these patients. However, on

the day of our inspection we found the RACU was at maximum capacity and all 6 patients were receiving NIV. Patients were cared for by 1 nurse with the support of a therapy assistant. This meant patients requiring close care and treatment due to their level of acuity may not receive the care and treatment required. This was also not in line with national guidance.

Staffing

The service still did not have enough qualified staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers continued to regularly review staffing levels and skill mix, however, no evidence of adjusting staffing levels based on dependency was observed.

The service still did not have enough nursing and support staff to keep patients safe. During this inspection, we found wards which were operating with reduced registered nursing staff. This was the case in our previous inspection which led to enforcement action.

The trust did not follow The Royal College of Nursing recommendations for safe staffing which was recommended as 1 nurse to 6 patients (expressed as 1:6). The trust used an alternative model which provided recommended staffing levels dependant on patient acuity and dependency (how unwell patients were, and how much additional care patients required such as patients with no mobility as well as their presenting illness) within wards. Staff in most areas told us there had been minimal improvements to staffing with most shifts still only operating with 2 registered staff members. Within some wards, staff told us this had improved to 3 registered staff members on each shift, however, this was still seen as a concern due to the acuity of the patients they were caring for and also the possibility of having staff taken from the wards to support other wards which had low staffing numbers. As a result of our inspection and the action taken, the trust as a whole had reviewed and updated their workforce plans, which had led to an investment in the workforce in some areas.

Following our previous inspection, we raised our concerns with the trust in the form of a section 29A Warning Notice which identified significant improvements were required in relation to staffing. We highlighted our concerns over wards which we identified as having a staffing ratio of 1:17 and the apparent impact this was having on safe care and treatment for patients. In addition to our observations on the inspection, information provided in relation to the section 29A Warning Notice and again after the inspection identified most wards had a minimal safe staffing ratio of 2 registered nurses per shift (with exceptions of AMU, wards 14, 23 and 24). This did not however include any additional staffing requirements due to enhanced nursing care being provided or if a registered mental health was required to provide a patient with support. In addition to the registered staffing ratio, the service also had a minimum safe non-registered staffing ratio of 2 healthcare assistants (HCAs) per shift with exception to the same wards and areas as identified for the registered staff. This meant the trust were accepting of the staffing to patient ratio of 1:17 in some wards as the minimum safe level of staffing and we found no evidence of consideration to the safety concerns which were raised following the inspection in December 2022.

Following the inspection, we raised our concerns over the lack of progress observed within some of the medical wards we visited in relation to staffing and requested assurance around the staffing models to ensure patients were receiving safe care and treatment. The response identified the trust continued to use a tool which based staffing on the acuity and dependency of the patients within the ward, although they acknowledged there were limitations with this due to this not taking into consideration the qualified nurse associates. The trust also provided an update on a full nursing workforce review which had taken place on all wards at Good Hope Hospital. The results of this review were due to be discussed at an internal governance meeting in June 2023.

Medical care (including older people's care)

On the 24 April 2023 we found Wards 15 had significant staffing shortages during the day shift. In the morning, there was 1 registered nurse on for the whole ward with 29 patients admitted at that time. In the afternoon, the registered nurse had been joined by a nurse associate to support them. The nurse had escalated this to the site management team and also their own matron.

On Ward 9 where we had previously identified concerns with staffing, we found there were 2 registered nurses on the day shift on the 24 April 2023 due to a short notice sickness absence, giving a staff to patient ratio of 1:17. Additional registered staff were due in for the afternoon shift, however, a nurse that was on shift at the time would be departing in the afternoon, this meant there was a risk staffing would remain too low to support safe patient care and treatment.

Ward 24 (respiratory ward) was identified as a ward which had previously had enough staff to safely operate, including the level 2 beds within their respiratory acute care unit (RACU). However, during our inspection we found the ward was understaffed to meet the needs of the patients on the ward. Within the RACU beds, the acuity of patients was high (calculated at 30 which was the highest it could be for the area). However, we found only 1 registered nurse and 1 therapy support worker was caring for these patients on the 24 April 2023. The nurse was also responsible for another bay of patients as well as a 'PUSH' patient (a patient who was moved to the ward to create additional capacity in either medical assessment unit or the emergency department under the 'Bristol Push Model'). Staff told us this was a frequent occurrence due to staffing shortages. During the previous inspection, staff told us Ward 24 had their staff ring fenced to ensure safe care and treatment could be delivered to patients within the RACU. However, during this inspection, staff told us it had been a frequent occurrence for the ward to send staff to support other wards if wards were short staffed. We escalated our concerns over this after the inspection and received further information from the trust. This identified there were 3 physiotherapists on the ward, 3 registered nurses, 1 therapy support worker and 1 healthcare assistant on shift on the day of inspection. Of these, 1 physiotherapist, 1 registered nurse and 1 therapy support worker were assigned solely to the RACU. However, our findings did not support this and the staff we spoke with confirmed this was not the actual staffing of the RACU at that time. In addition to this, the nurse was also given additional responsibilities. We were concerned that staffing reports did not reflect actual staffing levels.

We raised our concerns formally after the inspection and requested further information for assurance in relation to how the RACU staffing met the recommended guidance for acute NIV and requested where deviation occurred whether this was risk assessed. The information we received did not provide further assurance in relation to this concern. Information was shared again which contradicted the findings of the inspection team in relation to the staffing and also the acuity of the patients in the RACU area. The trust also shared the NIV policy which was in use at the time. It was noted that the appendix within this policy which referred to assessing the patient acuity level needed to be updated to include Good Hope Hospital. This was also highlighted in the trust's response. However, there was no evidence submitted which demonstrated how the trust assured themselves that the ward was providing safe patient care and treatment which was in line with, or risk assessed against, the recommended guidance.

We requested staff rotas for all medical wards for the Good Hope location. We found that all wards had shifts where staffing was lower than the trust identified safe minimum staffing for the ward. Some of the wards (Ward 24 and Ward 11) were identified as having low registered staffing numbers during the night shifts, whereas other wards (Ward 14, Ward 15, Ward 10 and Ward 9) had low staffing levels across all shifts. Within some ward areas we identified shifts where only 1 registered nurse or zero registered nurses were identified for a shift. We also identified a shift where only 1 registered nurse was rostered for a night shift on Ward 8 with no additional staff to support them. There was no additional information provided to identify additional members of staff were provided to support those who were rostered on to those shifts. We raised our staffing concerns with external bodies and also re-requested information from the trust to provide clarity and assurance over staffing level on these shifts.

The information we received after the inspection also identified staffing concerns for HCAs on all medical wards. We identified on Wards 14, 12, 24, 10, 9, 8 and 15, where only 1 HCA was to work on a shift. We observed shifts on wards 15, 8 and 24 where no HCAs had been rostered down for shifts. On 20 April 2023 there was no HCA rostered to work on the late shift on Ward 15. On 28 March 2023 there was no HCA rostered to work a night shift on Ward 8. On 22 April 2023 there was no HCA rostered to work on an early or late shift on Ward 24. On 24 April 2023 there was an HCA rostered on only for an early shift which was noted to end at 10.15am, after this there were no HCAs rostered on shift until the night shift on Ward 24. In addition to this, we observed night shifts which had HCAs covering twilight shifts only. This meant the ward would no longer have an HCA after a set period of time (for example 7pm until 3am) leaving the ward potentially short staffed. No additional information was received to identify what actions were taken to mitigate this or to identify whether any agency staff had been provided to support.

We included these concerns in the Letter of Concern that we sent to the trust. Information received in response to this identified there had been a data issue when preparing the rotas and a 'validation exercise' would be undertaken and shared (reviewing the data to ensure this was accurate). The trust shared revised rotas to replace those they had previously sent us as evidence which showed improved staffing for several shifts, although we still identified there were shifts with low staffing. On Sunday 23 April 2023, there was only 1 registered nurse on shift for the day on Ward 12. On Tuesday 11 April 2023 there was only 1 registered nurse on a night shift for Ward 9. On Ward 15 there was low non-registered staff on an early shift on 17 April 2023, a late shift on 4 May 2023, late shift on 5 May 2023, an early and late shift on 10 May 2023. Rotas showed on Ward 10 there was low non-registered staff on an early on 27 March 2023, a late shift on 28 March 2023, a late shift on 29 March 2023, a late shift on 30 March 2023. On 27 March 2023 the updated rotas identified there was no non-registered staff allocated to work on a late shift.

After reviewing all the information provided by the trust, as well as our findings at the time of our inspection, we were not assured that the trust had safe staffing levels to be able to provide safe care and treatment to patients. We therefore escalated our concerns to external partner organisations to ensure oversight and support was provided to the trust.

The planned number of staff rarely matched the actual numbers of staff. This was due to continued staffing pressures within most of the wards. On the day of our inspection only Ward 23 met the planned staffing for the ward. All other wards were showing gaps of at least 1 registered staff and 1 healthcare assistant. Ward 15 identified they were planned for 4 registered nurses to be on shift on the day of our inspection, however as detailed above, only 1 registered nurse was on the ward for the majority of the day shift. We also observed some ward areas which did not display the planned and actual staffing numbers for that day.

The ward manager or nurse in charge tried to adjust staffing levels daily. However, due to the overall shortage, this was not sufficient to keep patients safe. Where managers moved nursing or support from 1 ward to another to support gaps; this then left a gap on the first ward.

The service had reducing vacancy rates. Information received after the inspection showed the most recent vacancy rate for March 2023 was 13.05 whole time equivalents (WTE) across the medical services for qualified nurse staffing. There was an additional vacancy rate of 1.94 WTE for healthcare assistants. This was much improved since the previous inspection in December 2022. However, despite the information demonstrating staffing had increased, staff within most areas still told us they were working on minimal staffing for some shifts and that there were still vacancies for qualified nurses and healthcare assistants.

The service had an average staff turnover rate of 11.26% at the time of our inspection. This was slightly lower than the rate at the previous inspection and was in line with the trusts overall nurse staffing turnover which was reported to the trust board in April 2023.

Medical care (including older people's care)

The service had an average sickness rate of 4.55% at the time of our inspection. The was lower than the average sickness rate of 7.83% from the previous inspection and lower than the trust average of 6.25% at the end of March 2023. There were areas which reported a high level of sickness, for example Ward 15 which had reported a current sickness rate of 16.17% for nursing staff.

Managers did not limit their use of bank and agency staff and requested staff familiar with the service. When bank and agency staff were used, managers ensured they had a full induction and understood the service. Managers made effort to request the same staff where possible to ensure these staff were familiar and competent on the ward they worked. Some wards were able to request registered mental health nurses to help support with patients who required closer supervision of specific care and treatment.

Medicines

The service used systems and processes to safely prescribe, record and store medicines. However, we observed delays with the administration of medicines and there was evidence of medicines being missed.

Staff followed systems and processes to prescribe medicines safely. However, staff could not always administer medicines on time. In particular, we observed staff were delayed with morning medication rounds. On Ward 9, a member of staff told us it was not unusual to still be completing their morning medication rounds at 11am due to the staffing pressures they experienced. This meant some patients would not always get their medications on time. Staff told us they tried to ensure time critical medications were prioritised, however, they were not always able to ensure these were given on time.

Data from the trust showed performance was poor in relation to medicine administration. The clinical dashboard contained details of ward performance on missed antimicrobial administration, missed background insulin administration, missed enoxaparin administration and missed non-antimicrobial administration between December 2022 and April 2023. The performance was RAG (red, amber and green) rated to aid identification of how wards were performing. All wards were identified as requiring some improvements.

Wards 14 and 15 recorded the highest average percentage of antimicrobials that were missed (9.4% and 10.8% respectively). Homeward and Ward 8 reported the lowest average percentage of missed antimicrobials (3.8% and 3.9%) respectively.

Data showed better results for missed background insulin doses; although there were still areas of concern. Wards 21 and 18 recorded the highest average percentage of missed background insulin doses (11.6% and 9.1% respectively). Homeward and Ward 23 recorded the lowest average percentage of missed background insulin doses (0.8% and 2.8%) respectively. Despite other wards recording higher averages of missed insulin doses, there were wards which recorded no missed doses in April 2023. There were other wards which had also recorded no missed doses however, this did not appear consistent practice.

Data showed significant variation in administering enoxaparin (a blood thinning medicine). Wards 14 and 21 recorded the highest average percentage of enoxaparin doses that were missed recording 24.5% and 18.2% respectively. Ward 28 and Homeward recorded the lowest average percentage of enoxaparin missed doses recording 5% and 3% respectively.

Medical care (including older people's care)

All wards recorded a high (red) score when it came to missed non-antimicrobials that were administered between December 2022 and April 2023. Wards 28 and 21 recorded the highest average percentage of non-antimicrobials that were missed recording 21.2% and 20.2% respectively. Wards 15 and 8 recorded the lowest average percentage of missed non-antimicrobials administered recording 11.8% and 11.7% respectively. This meant that all wards were not consistently administering required medications to patients admitted on them, which could impact their recovery.

No additional information was provided which identified actions being taken to address the issues identified above.

Incidents

Not all staff reported incidents consistently.

All staff knew what incidents required reporting and how to report them. Staff tried to ensure they raised concerns and reported incidents and near misses in line with trust policy. However, due to staff shortages which impacted on time available to undertake duties, staff told us not all incidents were reported. Staff told us they mostly reported what they saw as the most serious incidents, however, incidents in relation to staffing were not always escalated as staff perceived nothing to happen in relation to them. Staff told us reporting of incidents continued to be something which they would have to complete in their own time or stay later following their shift to complete.

We requested information after the inspection in relation to all incidents raised which were solely related to staffing issues between 15 December 2022 and 24 April 2023. Information received showed there had been 61 incidents raised in total which were related solely to staffing concerns. The majority of these (46 incidents) were graded as no harm, 11 graded as low harm and 4 were graded as near miss. Wards 24 and 12 raised the most incidents in relation to staffing, raising 14 and 10 incidents respectively. The number of incidents raised in relation to staffing had decreased each month since December 2022 where 26 incidents were raised. There was a small incline from 3 incidents raised in March 2023 to 7 in April 2023. Although the information could be perceived as a reflection on the improvements within staffing on some wards, due to the rotas we reviewed and feedback from staff, this may also corroborate the feedback that staff no longer raise incidents in relation to staffing. As a result of the enforcement action taken after the inspection, staff are positively reporting staffing related incidents across all medical wards. The number of incidents had jumped from 8 being reported in April 2023 (around the time of our inspection) to 363 in July 2023.

We requested information after the inspection in relation to incidents which had occurred on the medical wards where staffing was identified as a contributing factor. Information received showed between 15 December 2022 to 24 April 2023, there had been 2 incidents where staffing was identified as a contributing factor. Both of these were graded no harm and had already been followed up. One of the incidents related to a missed medication round and the other was related to delays in obtaining assistance from a junior doctor.

The service had no never events on any wards since our last inspection in December 2022.

Staff mostly reported serious incidents in line with trust policy. Since our last inspection in December 2022, the trust recorded 15 serious incidents for the medicine core service at this location. The serious incidents were in relation to infection prevention and control concerns, treatment delay, pressure damage and falls. Infection prevention and control related serious incidents remained the highest category of incidents reported (7 reported) with pressure ulcer meeting SI (serious incident) criteria recording the next highest number (4 incidents). Since our inspection, Ward 12 had reported the largest number of serious incidents (4 incidents).

Medical care (including older people's care)

Is the service caring?

Good 

The rating for caring is the rating from the previous inspection in April 2023. During this inspection we did not look at all aspects of the caring domain, we therefore had insufficient evidence to re-rate.

Compassionate care

Staff did not always treat patients with compassion and kindness, and did not always consider their dignity. However, staff mostly took account of patients' individual needs and respected their privacy.

Staff were not always discreet when caring for patients. Staff did not always interact with patients and those close to them in a respectful and considerate way. During the inspection we were given feedback in relation to an incident where staff had been observed mocking a patient who was unwell. This had been observed by several patients and the family of the patient seen to be mocked. We were informed at the time of our inspection this had been escalated to the ward manager as a formal complaint.

Patient feedback indicated that care being provided on some wards was not always dignified. Examples were discussed of where patients were left for extended times in their own urine and excrement. Due to fear of being left for such long periods, some patients had requested their own mobility aids to be brought into hospital to enable patients to try and mobilise themselves to the bathrooms.

Information received from relatives after the inspection identified further concerns in relation to buzzers not being answered in a timely way and finding that patients were not always given the call bell to enable them to attract the attention of staff. In addition to this, concerns were also raised in relation to 1 patient where their dignity was compromised when staff told them to urinate on a pad despite the patient requesting to use a commode which they were physically able to do with staff assistance.

Patients said staff did not always treat them well and with kindness. Patients and relatives gave examples of poor care where staff did not treat patients with kindness and where staff attitudes were not in line with the values of the trust. Feedback was given in 1 ward where buzzers had been going for an extended period of time, however, staff did not come to assist the patients calling, instead they could be heard talking and laughing down the corridor. During our inspection, we did not observe any buzzers going off for extended periods of time, nor did we observe any patients waiting for extended periods of time for any assistance from staff.

However, other feedback during our inspection identified some positive examples of patient care, with 1 patient telling us all staff were 'lovely' to them and that they made her laugh. Another patient said how the staff had good attitudes and another describing staff as 'wonderful'.

Staff provided information about the Friends and Family Test to patients to encourage them to provide their feedback. Data showed an average of 92.2% of patients would recommend the medicine service to their friends and family for 2023. The data highlighted there were wards who were achieving a higher rate of satisfaction from patients who had used their services, for example Acute Medical Unit (AMU), Homeward, Ward 10 and Ward 15. However, wards 9 and 14 were scoring below this at 86.5% and 88.5% respectively.

Medical care (including older people's care)

Additional information received showed there had been 71 concerns, 19 compliments and 19 complaints received within the medical service between 15 December 2022 and 24 April 2023. No details were provided around the themes of the concerns or complaints.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

We were not assured all leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective in implementing meaningful changes that improved staffing and ultimately, patient safety. Not all staff saw leaders as visible and approachable.

We revisited the medical service to follow up on concerns in relation to staffing for the medical wards and the patients being admitted on to them. We found there had been little improvement to the staffing within the ward areas despite leaders identifying successful recruitment had occurred. Within some areas of the medical services, we identified a worsening situation in relation to staffing which staff identified was impacting on the care and treatment they were providing for their patients. After the inspection we verbally and formally advised the trust of our concerns in relation to staffing and the lack of mitigating actions. We requested that the trust provided further information which identified how they were continuing to work on resolving the concerns in relation to staffing. The information which the trust shared with us provided little additional assurance in relation to the staffing concerns. We were therefore, not assured that leaders within the medical services at this hospital had the skills and abilities to run the service.

Staff gave mixed feedback about the leadership across the organisation including local leadership such as line managers and matrons of the service. Where staff were positive about their immediate managers, there was an acknowledgement of some frustration in some concerns which had been escalated appearing to have no resolution. We also received similar feedback to that from our previous inspection in December 2022 in relation to the availability and visibility of some of the leadership team including some of the matrons.

Culture

Most staff still did not feel respected, supported and valued. Staff continued to raise their concerns however they did not feel they were listened to. Staff tried to remain focused on the needs of patients receiving care, however, the challenges in some areas were significantly impacting on their abilities to do this.

Staff felt undervalued and reported a reduction in morale in most areas we visited. Staff in some areas told us they were not able to provide high quality care and treatment to patients. As a result of staff identifying, they were not able to provide consistent high quality, patient centred care, many told us they would not want to be treated on these wards if they required a hospital admission; nor would they want their family members to be cared for at Good Hope Hospital. Some staff also told us they were ashamed to admit where they worked due to the negative feedback which the hospital had received in relation to the standards of care being delivered.

On a particular ward, staff reported how unsupported they had felt, especially as their manager had recently left. On the day of our inspection, we were aware of a staff member trying to get support due to the staffing numbers being low, however, they were unable to get the support that was required. In other areas we visited, some staff also told us how difficult it was to get the required support when concerns were identified. On another ward we visited, staff identified they would be down on the staffing for the night shift and had tried to escalate this a number of times during the day.

There were some exceptions to this where we noticed improvement within staff morale since our last inspection. Ward 16 where medical outlier patients were admitted was an example where they had gone through a positive transformation since the inspection in December 2022 and staff were positive about the place of work and the support they were given. This had been directly related to staffing pressures reducing due to an uplift in the number of staff recruited to that ward.

Some staff still spoke positively about their immediate managers and how they could approach them with their concerns and that they trusted they would escalate their concerns. However, there were still the concerns over the disconnect with escalation and evidence to demonstrate action was being taken. There was also still mixed opinions on the leadership above their local managers and their approachability and visibility.

Governance

We were not assured that leaders operated effective governance processes. However, as a result of the inspection, commissioners and stakeholders were promoted to provide external support to the trust.

Local leaders did not always have oversight of the full extent of the staffing shortages; and the impact this had on culture and safety, despite staffing being reviewed continuously. During the inspection staff told us about, and we observed, many staffing challenges across the medical wards. This included known low staffing for an upcoming night shift which was impacted further with short notice staff sickness. In addition to this was staffing challenges on a ward which had recently undergone some significant changes which had impacted on the leadership of the ward. This meant staff felt a lack of immediate support and chain of escalation. We had concerns over the oversight of these issues and the governance to support the known challenges that were evident. Information reviewed after the inspection showed all wards were challenged when completing staffing rotas. Staffing rotas were completed on average 4 weeks in advance which meant leadership teams were meant to have sufficient time to manage known staffing shortfalls. However, our findings during the inspection raised concerns over the processes in place for effective governance as there appeared to be little grasp of these challenges, with some rotas still identifying shifts where the minimal safe staffing was not met. We were therefore not assured the service had the governance processes in place to enable safe staffing to be managed and avoid situations where low or no registered nurses were due on an upcoming shift.

Following the inspection, we wrote a Letter of Concern to the trust to identify the concerns we had in relation to the governance around staffing and assurances for future staffing of the medical wards. Information we received identified there was a ‘daily staffing and unavailability look forward report’ completed regularly to highlight the immediate and upcoming staff shortages which required mitigation. The report highlighted wards where only 1 registered staff member was scheduled to work and also where no registered staff were scheduled to work. The look forward report provided the senior leadership team with up to 2 days’ notice of upcoming staffing shortfalls which required mitigation. In addition to this report, staffing was discussed up to 6 times a day during various leadership and workforce calls. Information shared by the trust showed even if staffing was not the primary focus for the call (for example the 3pm capacity meeting) staffing would be discussed and where possible allow the site team to consider placement of patients if staffing challenges were being faced. It was also at this meeting where considerations for the oncoming night staff would be

discussed and any shortfalls escalated. Although it was acknowledged that these processes were in place, this was observed to be very short notice and reactive monitoring of staffing which would be expected for short notice sickness of other short notice challenges,. We had concerns regarding the oversight of the longer-term issues where low staffing was recorded on the published rotas.

In response to the Letter of Concern, the trust provided a new standard operating procedure (SOP) for roster management which was due to be rolled out across the trust by the end of June 2023. This demonstrated the new process for oversight of the rota to ensure any shortages were escalated at the time of publication, therefore giving the service longer to fill any gaps. The matron for the service was responsible for the oversight of this and final approval for the rota to be published. In addition to this new SOP, staffing would now be reported to the Chief Nurse, Workforce Group to the People and Culture Committee and the trust board meeting with a view to updating the board on how the hospital safely staffs the medical wards at Good Hope Hospital. Although this provided some assurance around the oversight of the where significant gaps were identified, and well as escalation to the trust board, this was still to be rolled out and embedded and therefore there were still concerns over the staffing situation and potential gaps occurring.

The information shared by the trust identified there was a gap for maintaining accurate reflections of staffing on each ward. The systems used for the rota and that which calculated the financial impact of staffing did not enable staff who were moved to be reflected on the rota. The dashboard was also required to be updated to reflect staffing changes. However, this was not always completed and therefore not as robust as it could be. The rotas which were originally shared with the CQC were not identified as being in accurate at the time of sharing and therefore a validation exercise was required. The new rota's were identified as being accurate accounts of the staffing which had been checked at various levels. However, we still identified some shifts where staffing was recorded as low. Our concerns remained that the divisions were not accurately sighted on accurate information about the staffing within the medical wards and therefore we were not assured the governance processes in place around the staffing challenges were robust. As a result of our concerns, we escalated this to external partner agencies to ensure support was given and assurance was gained through oversight of the service.

The non-invasive ventilation (NIV) policy which was supplied provided a recommended staffing level dependent on the acuity of the ward/RACU. At the time of our inspection, the guidelines had not been updated to include the service at Good Hope Hospital, however, this was the guidance the service were working in line with locally.

Management of risk, issues and performance

Leaders and teams identified and escalated most relevant risks and issues however not all risks or incidents were recorded. After the inspection, external support was sought to support the management of the staffing risk.

The divisional risk registers reflected most of the risks we found on site. Staffing remained the top risk which all staff we spoke with told us about. However, the risk registers had not been updated to reflect this. In areas where staffing appeared to be more challenging than on the previous inspection, there did not appear to be any changes to the risk value and no additional measures added for mitigation. It was also noted that for Ward 24 which was now the respiratory ward, this had not been updated to reflect the change and still identified the respiratory ward at Good Hope Hospital as Ward 10. We also noted there had been no updates to the staffing constraints and the risk this posed in relation to ongoing strike action. The trust informed us risks were not allocated to wards on the divisional risk register and that staffing was identified on the trust level risk register due to the widespread risk to the trust.

Medical care (including older people's care)

Where data from the trust identified improvements to staffing since the previous inspection, staff told us this felt vulnerable, and staffing could worsen again quickly due to staff sickness and the requirement for staff to be moved to help other areas. This again, was not reflected within any of the risk registers.

Not all wards or specialities were reflected in the risk register despite staffing being short. The stroke and healthcare of the older population medical specialities did not have risks related to their staffing although our evidence demonstrated this was the case.

A risk we identified which was not reflected on the risk register was that of the 'Push Model' which aimed at increasing capacity within the emergency department by sending patients to other wards and departments. Staff told us how this increased the risk within their own areas and how they had verbally escalated this on numerous occasions. Whilst we appreciate this model was being used to support the volume of attendances at the emergency department, and a risk assessment at trust level was conducted, there was no evidence on any of the risk registers we received after the inspection which reflected the local risk which wards identified.

The trust was committed to responding to the staffing risk. Focused recruitment campaigns at Good Hope Hospital continued to run with the aim of focusing on the wards and departments where significant shortages were identified. As a result, significant numbers of staff had been recruited to some wards. Despite this positive action, staffing still remained a challenge in most areas. As a result of the findings of our inspection, we escalated our concerns to local external bodies who are trying to provide support to the service.

The service used a clinical dashboard to monitor real time performance and use this data for instant improvements. Within this dashboard was information on ward performance for a range of metrics which included completion of falls risk assessments, administration of antimicrobials, administration of enoxaparin, administration of background insulin and administration of non-antimicrobials. We reviewed the dashboard information for all medical wards at Good Hope Hospital and observed there was a number of wards consistently RAG (red, amber and green) rated red for their performance on the metrics between December 2022 and April 2023. We specifically reviewed areas which had been raised as a concern during our inspection which staff believed were compromised due to staffing challenges, this included falls risk assessments and the metrics related to medicine administration. We reviewed minutes from divisional meeting to review how these challenges in performance were escalated and how the leadership team challenged teams for plans on how they intended to improve. However, the minutes did not indicate there was a thorough discussion around the performance of wards within their divisions. We were therefore not assured there was the oversight within the divisions of the challenges in relation to dashboard metrics and no identified drive from the top for improvements, which ultimately impacted patient care and treatment.

Urgent and emergency services

Inadequate ↓

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate.

Mandatory Training

Not all staff were up to date with mandatory training in key skills including the highest level of life support training. Staff were not trained in working with patients with learning disabilities or autism.

Not all staff received or kept up to date with their mandatory training. The trust had a compliance target of 90% for staff training.

Out of a total of 101 staff based within the Emergency Department 61 (60.4%) staff had completed fire awareness training.

Out of 101 staff, 71 (70%) staff had completed training in information governance.

The service provided EPLS (European Paediatric Life Support) and ALS (Advanced Life Support) training for staff roles including advanced clinical practitioners, consultants, emergency nurse practitioners, and nurses. Out of 137 eligible staff and training target of 90%, 100% of staff had completed resuscitation training to the required level. The data also stated that 30 staff members training had expired. However, The service told us they ensured there were a trained nurse on every shift with the paediatrics department and there is always medical staff trained in APLS on every shift.

Details of training modules where compliance met the trust target are below:

- Corporate and local induction
- Inclusion and diversity
- IPC (Infection Prevention and Control) (infection prevention and control).
- Manual handling
- Resuscitation awareness
- Prevent
- Health and safety
- Manual handling

Clinical staff completion rates for training on recognising and responding to patients with mental health conditions, learning disabilities, autism, and dementia were very low. The mandatory training did not always meet the needs of patients and staff. The Health and Care Act 2022 introduced a legal requirement that providers registered with the CQC (Care Quality Commission) must ensure that each person working for the purpose of regulated activities carried on by them receives training on learning disability and autism.

Information provided by the service did not indicate the number of staff that should have completed this training, however, this stated that no staff were trained in autism awareness, and only 1 staff member had received training in supporting people with a learning disability. This meant the service was not compliant with legal requirements.

Although information provided by the service did not state the total number of staff eligible for specific training, the data provided showed only 25 staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training within the department, and only 9 staff had completed mental health awareness. Only 35 staff had completed 'capacity, consent and best Interests' training.

Within the department only 5 staff had completed training in dementia level 2, 5 staff were trained in understanding dementia, and 7 staff trained in 'dementia - positive approach to care'.

Safeguarding

Staff did not always understand how to protect patients from abuse. Not all staff had training on how to recognise and report abuse and they did not always know how to apply it.

Nursing staff mostly received training specific for their role on how to recognise and report abuse. However medical staff training compliance did not meet the trust target.

Eighty-four percent of all staff within ED had completed training in safeguarding children and adults level 2. For nursing staff and paediatric nurses, the 90% target was met.

Eighty-six percent of paediatric nurses had completed training on safeguarding children level 3. However, the completion rate for all eligible staff for safeguarding children level 3 was 48.4%.

Medical staff were not compliant with the trust target for safeguarding training. Of junior doctors, 66.7% had completed training for safeguarding adults and children level 2, and safeguarding adults level 3. No junior doctors had completed training in safeguarding children at level 3.

Seventy-one percent of consultants were trained in safeguarding children and adults for both level 1 and 2.

Following the inspection, the trust completed a training plan to ensure all staff were level 3 trained by July 2023.

The service has a safeguarding team trained to level 4 and one dedicated ED child safeguarding nurse who works 3 days a week. All the team that cover adults and children ED and are trained to level 4. The service also had a safeguarding telephone line that staff could call Monday and Friday between 8am and 4pm. However, there was no-one trained to level 4 safeguarding available for staff to contact at weekends or out of hours. This created a risk that safeguarding referrals were missed or delayed, and staff did not have appropriately trained staff to support the department which regularly saw and treated vulnerable adults and children.

Urgent and emergency services

Staff did not always know how to identify children at risk of, or suffering, significant harm. The service had a safeguarding procedure in place. However, during the inspection staff we spoke with did not always understand specific types of abuse, such as sexual assault and rape in children. Staff were not always clear about how to respond when they identified potential abuse. Staff did not know when to involve or refer to outside agencies.

Not all staff knew how to make a safeguarding referral to protect children and who to inform if they had concerns. Staff had some general knowledge of the process of raising safeguarding concerns. However, during the inspection, we identified 1 child who had attended the department who may have been at risk and a safeguarding referral had not been made to the local authority. We raised this with staff who then made a safeguarding referral.

Information received following the inspection showed that since October 2022 there had been 46 missed opportunities to raise concerns relating to children's safeguarding, this had been identified by the paediatric liaison service (PLS).

Data also showed that since October 2022 there had been 127 missed opportunities to raise concerns relating to adult safeguarding

The safeguarding risk assessment had not been completed for 88% of 16 to17 year olds who attended the adult Emergency Department since January 2023.

There were 11 assessments that had not been completed for safeguarding risk assessments for adults during the period of January 2023 to March 2023.

However we saw evidence that staff made referrals for patients who presented with mental ill health when safeguarding concerns such as domestic abuse were identified.

Staff mostly followed safe procedures for children visiting the area. The service ensured that once children arrived at the urgent and emergency department, they were booked in at the reception area and then went straight to the children's department. This meant that children were kept separate from adults whilst waiting to been seen by a doctor.

The service had an abduction and missing person policy and procedures in place. However, staff did not complete abduction drills within the department, which meant if an attempted abduction took place staff within the department may not know how to respond.

Staff took children from the paediatric Emergency Department into AMU (Acute medical unit) which is an adult ward, to use the shower facilities if required. The service had a risk assessment in place for this which identified the reasons why they were taking children into an adult unit. However, this did not identify the safeguarding risks or how staff should protect children whilst they were there. Since the inspection, the trust has begun to progress plans for a shower installation within the children's emergency department.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use PPE equipment and control measures to protect patients, themselves, and others from infection.

Most areas of ED were clean however we saw one incident of potential contamination. The service had suitable furnishings but not all were cleaned and well-maintained. The service had an IPC policy in place, all cubicles and paediatrics rooms were visibly clean, and free from clutter.

The service used “I am clean” stickers to identify when equipment had been cleaned. However, the resuscitation trolley and suction unit within paediatrics had a ‘I am clean sticker’ attached but were visibly dusty, indicating the stickers were not accurately reflecting cleanliness of all equipment.

During the inspection there was evidence that deep cleans of areas had been completed by the domestic staff. However, we found following a flood from the patient toilets which leaked into the waiting room. The team conducting a deep clean disposed of the dirty water outside of the urgent and emergency main doors. This meant the dirty water was in the ambulance bay and subsequently ran down the footpath leading into the department. Cleaning staff used ‘wet floor’ signs to indicate floors may be slippery.

A sofa was damaged in the mental health room and could potentially be an infection risk to patients. This had been raised with the matron who took action to get the sofa removed from the area.

Staff did not always follow infection control principles (IPC) including the use of personal protective equipment (PPE). Staff were required to wear masks within the department. We observed these were not always worn correctly, and some staff had them placed underneath their chins. We also observed not all staff ensured they were bare below the elbow, as required by the trust’s IPC guidance.

We saw dispensers for hand sanitiser attached to walls regularly throughout the department. However, some dispensers did not work or were empty. This meant staff, patients and visitors had less opportunity to decontaminate their hands whilst in the department.

The service had a 90% pass rate in relation to hand hygiene audits. From March to 11 May 2023 data received stated the average rate was 91%.

Environment and equipment

The design, maintenance and use of facilities, premises, and equipment mostly kept people safe. However, the mental health room raised concerns relating to safety of both patients and staff. Staff managed clinical waste well.

Staff mostly carried out daily safety checks of specialist equipment. Staff had completed daily checks of the resuscitation trolley within paediatrics for January and February 2023. However, on 28 March 2023 and 6, 11,12,16 April 2023 the record indicated the daily checks had not been completed. All other resuscitation trolleys were in date and had been checked.

All suction unit and defibrillator tests were due August 2023, and were in date.

Maintenance staff completed portable appliance testing (PAT) on all electrical items in the department. We saw these were completed in April 2023. All equipment passed and was safe to use.

Managers had created an ambulance decisions area which was staffed by senior paramedics and emergency care assistants from the local ambulance trust. Patients who could be seen by this team were directed here to be seen more quickly.

Urgent and emergency services

The mental health room was partially compliant with quality standards published by the Psychiatric Liaison Accreditation Network (PLAN) for Liaison Psychiatry Services. The room had 2 doors to enable patients or staff to easily enter or exit the room from different points. However, the room had 1 alarm button on the wall. This was not in line with the quality standards which recommend strip alarms across 1 wall or for staff to carry panic alarms. This was a potential risk to both patients and staff.

During the inspection doctors told us they were not aware of the mental health room and were not aware of the procedures to support patients in the room. This meant that patients were being kept in main busy areas with other patients, in the plaster room or a room designed to assess eye complaints, which could be a risk to the patient and other patients, as well as the staff.

CCTV enabled the mental health room to be viewed at the nurse's station; to monitor patients from outside the room. However, the positioning of the camera meant the whole room was not covered, so staff may not be able to monitor patients fully, which could potentially be a risk to the patient.

The service did not have a risk assessment in place at the time of the inspection in relation to the mental health room. Following the inspection feedback, a risk assessment was completed.

We raised concerns with the service during the inspection in relation to hooks and wires which were identified within a paediatric room as a risk to children and young people who presented with mental health concerns, as these could be used as ligature points. Staff told us they would use the wellbeing room situated in the paediatrics department, which is an area free from wires and hooks. However, they did not complete a risk assessment until 11 May 2023 which was after this risk had been identified during the inspection.

The service mostly had enough suitable equipment to help them to safely care for patients.

The service used specialist mattresses that fitted on to trolleys, which meant if patients were using a trolley for a long period of time the risk of pressure ulcers was reduced.

The service had 2 electrocardiograms (ECG) machines to monitor patients' cardiac activity, and 2 blood monitoring machines for the whole department. This meant if there were more than 2 patients requiring these machines patients would have to wait until 1 became available.

Staff disposed of clinical waste safely. Clinical waste bins were closed and foot operated. All sharp bins were stored correctly with the lid closed and they were not filled above the identified fill line.

Not all hazardous substances were secured. COSHH (Control of Substance Hazardous to Health) items were kept in a lockable cupboard, however we noted a bottle of specialist antiseptic wash had been left out and not safely secured.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments including sepsis assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Urgent and emergency services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used National Early Warning Scores 2 (NEWS2) to monitor adult patients for deterioration. Staff in paediatric ED used Paediatric Early Warning Scores (PEWS) to monitor children. We saw these were being completed, and that staff were monitoring the patients, and these had been calculated correctly.

Staff had received training on sepsis and the management of sepsis. During the inspection we looked at 15 patient records and found risks associated with sepsis, where relevant to the patient, had been assessed and documented.

The service had a deteriorating patient policy and Standard Operating Procedure (SOP) in place to monitor deteriorating patients.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly. When walk-in patients arrived at the department, after booking in they were seen by a navigator; a band 6 nurse with additional training, who streamed patients to the most appropriate area based on risk. Patients were then triaged using a national triage tool to determine what tests or investigations may be required and to determine how ill the patient was.

A hospital ambulance liaison officer (HALO) employed by the local ambulance trust, and a senior nurse employed by the hospital, were also present coordinate incoming ambulances to appropriately stream patients to the best pathway depending on patients' clinical need.

This allowed the nurse in charge, consultant in charge and anyone else to see who was next to be seen by the clinicians according to a priority score. Recording the acuity and priority score of the patients in the waiting room on arrival provided assurance to the nurse and consultant in charge that the sickest patients had been identified and action taken to ensure they were seen first.

Staff knew about and dealt with any specific risk issues. Staff worked with patients who at times demonstrated aggressive and/ or violent behaviour. Security guards employed through a third-party company worked on site to support staff to manage antisocial behaviour.

The service had a procedure entitled 'Managing Patients/Public Whose Behaviour is Inappropriate, Violent and/or Abusive.' This was used by staff to monitor patients who had displayed behaviours that were inappropriate, violent, or abusive. Patients who displayed these behaviours were given a verbal warning first, then a 'yellow flag,' followed by a 'red flag' if the behaviour continued. Patients with a yellow flag would still receive care; and an investigation around the safety of the patient to be seen in future would take place, which remained on records for a year. Where patients continued to behave in a way that put staff and other patients at risk; or behaved in a way initially that put other staff and patients at extreme risk of harm; a red flag was added to their records. This meant they would not be able to receive care or treatment from the department for 2 years. However, staff told us that ambulance staff did not have access to the flags on the trust system, so they would still bring patients to the trust. Staff told us where this happened the department would treat the patient, and make sure security was present. Once treatment was finished the patient would be discharged.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff could access the psychiatric team and make direct referrals.

The service also used a “this is my wellbeing (mental health) hospital passport,” which identified wellbeing, coping strategies and how best to support the patient in a time of crisis.

The service could liaise with Child and Adolescent Mental Health Services, delivered through a local NHS trust to manage children with severe or deteriorating mental ill health. However, staff told us the criteria for referral had changed and children would no longer be seen within the ED. Instead, children had to wait until they were discharged from the hospital to be seen, unless they had stated they planned to harm themselves, in this case children would remain in hospital to be monitored. If the children did not display harmful behaviours, then they would receive this care in the community.

The service had an overdose and drug and alcohol withdrawal policy, which staff could follow if a patient presented within the department with these concerns.

Nursing staff

The service did not have enough nursing staff and support staff keep patients safe from avoidable harm and to provide the right care and treatment; however, they used agency staff to make up some shortfalls. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff to keep patients safe. The service had a total of 916 shifts for the month of April 2023 which, after the use of bank and agency staff, were not filled. This meant 31% of shifts within the adult's department were unfilled.

The service had a total of 251 shifts for the month of April 2023 which were not filled, which equated to 50% of staff shortages within the paediatrics department. However, the service told us that there was a staff member on shift trained in paediatrics life support on every shift.

The service was very reliant on the use of agency and bank staff, who were used to help cover vacant shifts. Managers made efforts to fill staffing gaps with bank and agency staff; however, there were still vacant shifts.

The service had increased rates of bank and agency nurses. Within the adult’s department for the month of April 2023 there were 773 shifts filled by agency staff which equated to 26% of all shifts. There were 373 shifts filled by bank staff which equated to 13%.

Within the paediatrics department for the month of April 2023 there were 38 shifts filled by agency which was 8%. There were 47 shifts covered by bank staff which was 9% of the total shifts.

Managers requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, there was not always sufficient staff numbers to cover this. Staffing ratios were calculated based on The Royal College of Emergency Medicine guidance. Six monthly workforce reviews were undertaken which included acuity and attendance information to ensure service demand was incorporated into up-to-date requests for workforce planning.

Leaders told us when the service was understaffed escalation actions were undertaken and there was divisional oversight of the staffing position. Local actions were reviewed by an ED nurse manager and a matron. If they were unable to mitigate the risk, escalation was completed to the Deputy Director of Nursing. When necessary, the site team reviewed the overall site and divisional workforce position to support planning to ensure safe staffing was balanced across each area.

The service had high vacancy rates. The department had a 30% nursing staff vacancy rate.

The service had increased turnover rates. The service had a target of 9% for staff turnover, however the current staff turnover for April 2023 was 14.11%.

Nursing turnover rates remained higher than the trust average and the target for this metric. Exit interviews were completed and stay interviews were launched across the speciality.

The themes identified by the trust for why nursing staff were leaving are that majority of staff that have left are not seeking employment in other emergency departments and are leaving Emergency Nursing over concerns around overcrowding and increased length of stay within the Emergency Departments.

The service had reduced sickness rates. For nursing staff over the last 4 months sickness levels had decreased from 3.43% to 3.16%.

For administration and clerical staff over the last four months sickness levels had increased from 1.70% to 6.67%.

The service monitored staff absences and, where appropriate, referrals were made to occupational health services to seek further support and guidance.

Reviews were undertaken monthly to identify any trends or themes relating to sickness absence.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe. For the month of April 2023, the service was reliant on the use of locum staff. Locum staff were used to help cover vacant shifts.

The service had a total of 33 shifts for April 2023 and there were 16 shifts in May 2023 which were not filled by medical staff.

During the month of April 2023 there were 1,002 shifts that needed to be covered and the department covered 563 shifts, which was 56.19%.

During the month of May 2023 there were 1,042 shifts that needed to be covered and the department covered 543 shifts, which was 52.11%.

For the junior medical workforce, the department was budgeted for 86.8 whole time equivalent (WTE) and there were 108.22 WTE in post. This meant the department had 21.42 WTE more staff than required.

Staff told us there was a lack of paediatric consultants for the Emergency Department and it was difficult to get a consultants to come into the department.

Managers could not always access enough locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service required the support of locum staff to cover vacant shifts, the service tried to ensure that locum staff were regular and knew the service. Locum staff were given an induction to the service.

Managers used regular locums and GPs (General Practitioners) with special interest as middle grades to cover rota gaps.

The service had high vacancy rates for medical staff. The service had 25 consultants that covered the service and a second site. However, the service was currently recruiting for 8 more consultants.

The service told us that to meet the 1 whole time equivalent (WTE) consultant/4,000 patient ratio, they would require an extra 50 WTE consultants across the 3 trust ED sites.

The service had low turnover rates for medical staff. The service had a staff turnover rate of 6.52% which was lower than the trust target of 9% for medical staff.

Sickness rates for medical staff were reducing. The service had a sickness rate of 3%, which was lower than the Trust average of 9% for March 2023.

Consultants were required to attend computerised tomography (CT) scans to support contrast procedures during the night, when required. These were in the imaging department and were not close to the department. This meant that there was 1 less consultant available in the department during the time of this procedure.

The service always had a consultant on call during evenings and weekends. The service ensured that there was a consultant on shift between 8am and 11.30pm, and a senior decision maker was allocated to work overnight till 8am. This consultant would also cover the paediatric emergency department.

Records

Staff kept detailed records of patients' care and treatment. Records for most patients were clear, up to date, stored securely and easily available to all staff providing care. However records for patients who presented with mental ill health were not always up to date.

Patient notes were comprehensive, and all staff could access them easily. All patient records were clear and comprehensive. Adult patients' records were stored electronically. Paediatric patient records were in paper format. There were plans for all departments to move to the same system soon.

During the inspection we reviewed 10 patient records which there was only 1 patient record who had a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) form in place, which had been completed correctly.

We reviewed records for patients who had presented with mental ill health. We found there were several records where there was not sufficient detail particularly where patients went to a designated mental health hospital from the ED, for example which mental health ward the patient went to.

We saw significant gaps between the actual assessment undertaken by liaison psychiatry and documenting this on the recording system. However, we acknowledge that the liaison psychiatry team were employed by a separate mental health trust.

When patients transferred to a new team, there were no delays in staff accessing their records. We witnessed staff preparing paperwork for patients to be able to move on from the department, this ensured that relevant information was shared between staff and other professionals.

Records were stored securely. Records were stored securely. Paper records were kept in a locked trolley and screens were closed when not in use so people passing by could not access patient information.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, there was no policy or guidance for the use of rapid tranquilisation.

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed all medicines and prescribing documents safely. All medicines and prescriptions were stored in a locked room and controlled drugs were secure in a locked cupboard within this room.

Controlled drugs (CDs, medicines requiring more control due to their potential for abuse) were stored safely and securely with access restricted to authorised staff. Checks were undertaken and recorded by two staff twice a day. Checks of CDs showed that they were within date and stock balances were accurate.

All CDs were delivered to the nurse in charge (NIC) in a sealed bag by the pharmacy porter. These were signed for straight away by the NIC and a second registered nurse.

The service completed 6 monthly safe and secure handling of medicine audits. This had been last completed in October 2022 and gave information about how the department was complying and in which areas they were not meeting the required standards. This included good practice, such as keys being kept with a designated person, medicines kept safe and secure, appropriate stock levels, refrigerators in good working order and all medicines stored in date and signed and dated when opened. These included tablets intravenous (IV) fluids, oral solutions, and injectable medicines.

Two weekly medicines management audits were completed in collaboration with pharmacy on each site with an overarching action plan tracking the specific requirements for each department. Over the last 12 months improvements were documented; this included the implementation of new medicine storage areas.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The trust had their own in-house electronic prescribing and medicines administration (EPMA) system. It provided information in one place including the patient's medical requirements, a medicine history and provided up to date information on prescribing. Where dose adjustments needed to be made for weight-based medicine prescribing, the system alerted the prescriber and calculated the correct dose.

Staff completed medicines records accurately and kept them up to date. During the inspection 10 sets of patients' records were viewed and 8 sets of records had medication charts to monitor what medication patients were taking, the dose and the times at which the medications needed to be taken, and 2 patient records hadn't had medication administered. All medications had been signed by the person administering the medication.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff undertook medicine history reviews and clinical checks on prescribing. This ensured patients' medicine records were up to date and accurate before they were admitted or moved between services.

Staff learned from safety alerts and incidents to improve practice. The service shared information within the department in relation to safety alerts and learning from them. However, the service did not complete audits on missed doses of medication.

The trust had a Medicines Safety Officer (MSO) in line with NHS England directives. The MSO investigated concerns about safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents.

The service had no policy in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There was a 'Children, Young Person and Adult Restraint Procedure' (24 June 2022), however, there was no policy or guidance for the use of rapid tranquilisation which may be used where urgent sedation is needed for managing violence and aggression. This meant there were no clear guidelines on place to direct staff.

Incidents

The service did not always manage patient safety incidents well. Staff did not always recognise and reported incidents and near misses or reported them appropriately. Managers did not always share lessons learnt following incident investigations or hold staff debriefs after serious incidents. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff did not always raise concerns, or report incidents and near misses in line with trust policy. Staff told us they had completed incident forms on an electronic system, and these would be looked through by the senior staff.

However, during the inspection we identified a patient who had been transported to a different hospital for treatment by mistake. When we requested information about the patient, the service could not identify the patient, or the incident form that had been completed.

The service told us themes and trends were regularly monitored in the department. As part of the wider divisional governance structure the ED had a speciality level meeting where themes and trends were reviewed.

Leaders attended 'Patient Experience Group' and 'Preventing Harm' meetings where themes and trends from incidents and complaints and patient feedback were reviewed. Findings from these meetings were reported into the 'Divisional Quality and Safety' meeting which reported into the Divisional board. . The division also reported to the Joint Clinical Quality and Assurance Group on quality and safety matters, including themes and trends. This was co-chaired by the chief nurse and chief medical officer.

Urgent and emergency services

The service had not had any never events.

Managers investigated incidents thoroughly. Local leaders completed serious incident reviews when something went wrong.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff told us they did not always get the feedback or information about the outcome of certain incidents from managers. For example, a theme of delayed diagnosis incidents had been reviewed. However, staff told us they had not received sufficient feedback from the investigations to promote timely learning and changes to practice.

However general trust wide themes and trends from incidents which were shared with staff using a newsletter.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The service had a duty of candour policy and staff understood the importance of this. They were transparent in giving patients and families an explanation of events that had gone wrong. We saw an example of the duty of candour being applied following a serious incident.

Managers did not regularly debrief staff after any serious incident. Staff told us they did not have debriefings for incidents unless they were recorded as serious incidents. These included examples of falls, pressure ulcers, or a death of a patient. This meant staff did not get the opportunity to learn from harm reviews or investigations to improve practice and patient safety.

Managers monitored patient safety alerts and ensured staff were aware of any changes relating to patient safety that need to be implemented. For example, following a national patient safety alert, local leaders created a patient safety notice relating to the safe use of oxygen cylinders.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. During the inspection we looked at the department regarding implementing clinical guidelines from the National Institute for Health and Care Excellence, also alongside those of other professional bodies such as the Royal College of Emergency Medicine (RCEM). For example, the service completed a neck of femur audit which identified that they were managing pain correctly, and what the recommendations and actions were. However, this data shared by the trust was dated 2020 and 2021. There was a lack of updated data due to clinical audits being paused during the COVID-19 pandemic.

Urgent and emergency services

Staff followed national clinical guidance to undertake assessments such as sepsis screening.

The service had followed non traumatic chest pain indicators guidance; however, the service told us that they did not audit the response times from the patient attending the department to having an ECG completed. This meant a lesser opportunity to learn from practice and improve patient outcomes.

Staff did not always protect the rights of patients subject to the Mental Health Act and followed the Code of Practice. The service worked closely with the psychiatric team, and there were processes in place to protect patients subject to the Mental Health Act. However, during the inspection we observed a patient who presented in the department with mental ill health who did not receive a timely assessment around the risk the patient posed to both themself and other patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff ensured patients received food and drink, including those patients who were waiting on ambulances. Staff told us patients with specialist nutrition and hydration needs were also supported as required, however we did not witness this during the inspection.

Patients and families could also have access to a nearby hospital café, and there were vending machines within the department.

Patients told us that they received food, such as a sandwich, when they arrived in the department during the night.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff were trained to recognise and monitor pain. Within the 15 records reviewed; staff had assessed and reviewed patients' pain where required.

Patients received pain relief soon after it was identified they needed it, or they requested it. Staff prescribed, administered, and recorded pain relief accurately. Staff clearly documented this within patients' records.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Urgent and emergency services

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent, and met expectations, such as national standards. The service had participated with Royal College of Emergency Medicine (RCEM) quality improvement programmes (QIP).

Medical staff completed local audits, some of which led to publication in the RCEM learning resources and national presentation. Audit leads for each site regularly monitored the audits, ensuring RCEM and local audits were regularly completed and shared with the team. These had led to improvement in practices such as the introduction of prepack for FIB and guidance notes for colleagues, local safety standard for invasive procedures (LOCCSIP) for chest drain insertion and several QIPs (quality improvement programmes) in the departments.

These projects had helped improve the quality of care provided to patients. These include safeguarding audits and IPC, environment, hand hygiene audits and catheter care and insertion. These projects were undertaken by a team of juniors, consultants, nurses, and research team and relevant learning was shared with the Emergency Department team.

The service benchmarked themselves against other teaching trusts within the country and the main trusts averages were approximately 75%. The data shows from July 2022 to December 2022 the trust was between 66% and 72%.

Managers and staff used the results to improve patients' outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. At the time of the inspection, managers within ED were producing a new clinical standards quality assessment tool which would be rolled out towards the end of May 2023.

Managers shared and made sure staff understood information from the audits. The service held meetings to discuss audits and then shared this information with the local teams to ensure they had insight and could make any improvements.

The service had a risk of re-attendance that was lower than the England average.

The department’s unplanned reattendance rate within 7 days (which included any readmissions within 7 days of departure) was low at 7%.

Unplanned readmission rates within 72 hours for patients who presented in the department with chest pain was just above 2%.

Competent staff

The service did not always make sure staff were fully competent for their roles. Managers did not complete appraisals for staffs to monitor work performance.

Not all staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The service did not ensure that all staff kept up to date on mandatory training, this included EPLS (European Paediatric Life Support), ALS (Advance Life Support) and fire training.

The service did not ensure that all staff were trained in safeguarding, and staff within paediatrics had limited understanding in relation to safeguarding children that may have been placed at risk harm or abuse.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us they had received an induction, this included all levels of staff, and involved student, agency, and bank staff.

Managers did not support all staff to develop through yearly, constructive appraisals of their work. The department had a target of 90% to meet in relation to staff appraisals. However, Out of 134 eligible staff, only 51 staff had received appraisals which equates to 38%.

The only staff teams that met the trust appraisal target were medical secretaries.

Other staff groups were as follows:

- Paediatrics staff were at 71.4%
- Consultant medical staff were at 61.9%
- Most emergency nurse practitioners worked across both trust sites, the appraisal completion rate was 67%.

We recognised that the local management team had plans to address the appraisal rates.

The chief medical officer's services team worked closely with the senior medical leads for revalidation and appraisal to support non-trainee medical staff with their appraisals.

The clinical educators supported the learning and development needs of staff. The trust had clinical educators in place to support the learning and development of the staff with their training needs. The team were recruited to introduce a structured education plan for staff of all grades.

Managers identified any individual specific training needs to support their staff and gave them the time and opportunity to develop their skills and knowledge to enable the staff to work towards promotions. During the inspection we spoke with staff who stated they received support from managers to be able to develop their skills and knowledge, and some staff had recently been promoted into higher roles.

Managers identified poor staff performance promptly and supported staff to improve, However, policies were out of date. The service had policies and procedures in place to monitor poor staff performance, The policies and procedures included a disciplinary procedure (review date September 2022) and an employee relations policy (review date June 2022), these policies were overdue a review.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service completed flow meetings and doctors' handovers, which we observed during the inspection. This is where staff come together to discuss patients' waiting times, patient journeys and staffing for the next shift.

Staff told us there were good relationships between doctors, consultants, nurses, and paramedics who worked together closely to provide the care to patients.

Patients who were frail and vulnerable were referred to 'older person assessment and liaison' (OPAL) team.

Staff worked closely with OPAL team, the vulnerability team, and the psychiatric liaison team.

Urgent and emergency services

Staff worked across health care disciplines and with other agencies when required to care for patients. The trust worked with local ambulance NHS Trust. A hospital ambulance liaison officer (HALO), senior paramedics, were based at the department's ambulance entrance. They provided a link between the ambulances and the emergency department, to help ensure patients' handovers are given to the department staff.

During the inspection we identified staff liaising with each other about the vulnerability of a patient who kept re-attending the department. Examples of this patient's care were discussed, and the team were meeting all the patient's care and needs.

During the inspection, we observed staff work collaboratively with police to support a patient holistically. Staff could also access a trust based member of the local police force for advice as part of a pilot project for managing antisocial and offending behaviour.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The staff team had access to the psychiatric team who had a 60-minute target to see people in ED. However, the average wait time was 120 minutes, which means the service had not met their 60-minute target.

During the months of December 2022 and February 2023 the service had 333 patients who met the criteria for referral that attended the department, just under 100 patients left without been seen and 200 patients were referred to the psychiatric team. The data did not clarify what happened to the 33 patients.

Patients were referred on to appropriate pathways once discharged from liaison psychiatry such as homeless pathway and the alcohol liaison team.

Seven – day services

Key services were not available seven days a week to support timely patient care.

Staff could not always call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. We acknowledged the liaison psychiatry team was working under a service level agreement as they were employed by a separate mental health NHS trust. However, the service was not always sufficient to provide support within agreed timescales.

The service did not have 24-hour 7 day a week cover for the safeguarding team or the OPAL team. These teams worked from Monday to Friday until 4pm, the safeguarding team are based in the hospital 5 days a week. This means that the department did not have support when raising a safeguarding or seeking support. during out of hours and bank holidays.

The service had seven-day consultant cover for emergency attendances. Consultant presence in ED was from 07:00-00:00, and on call at other times.

The service had access to a seven-day service for X-ray and blood tests.

Prior to the Covid-19 pandemic, the trust carried out audits of compliance with the seven day services standards. The national requirement to undertake these audits was suspended due to the pandemic. The trust planned to restart the manual audit programme from Autumn 2023.

Urgent and emergency services

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff assessed patients on an individual basis and provided support and advice to encourage the patient to have a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, not all staff understood their responsibilities under the Mental Capacity Act.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The service used the therapeutic observations and engagement for mental capacity tool, which is a risk assessment and care plan. This clearly identified if the patient was subject to a Deprivation of Liberty Safeguards (DoLS), and who had been present to complete the care plan. It also identified if daily reviews and reassessments of the risk had taken place in line with the Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff within the adult Emergency Department understood gaining consent from patients in relation to their care and treatment in line with legislation, and this had been documented within the patients' records.

During the inspection we looked at 10 records relating to adults and there had been one patient whose presentation indicated they would benefit from an assessment to identify if they had the mental capacity to consent to care and treatment. We found this had been completed correctly.

Not all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service did not identify how many staff they had that should undertake this training, however, they had 36 staff trained in Mental Capacity Act and DoLS, and 35 staff trained in capacity, consent and best interests.

The policy around consent, the Mental Capacity Act and Deprivation of Liberty Safeguards was out of date. The service had a mental capacity and best interests' policy which explained undertaking mental capacity assessments and making decisions in the best interests of patients. This also included information relating to children under 16 and referenced Gillick competency. However, this policy was reviewed in November 2022 as planned.

Is the service caring?

Requires Improvement ↓

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

Urgent and emergency services

Staff did not always respect patients' privacy and dignity, or account for patients' individual needs. However, staff treated patients with compassion and kindness.

Staff were responsive when caring for patients. Staff took time to interact with patients and those close to them in a considerate way. Staff were responsive when caring for patients, staff would ensure that the patient received the care and treatment required. We observed staff supporting a vulnerable patient who regularly attended the hospital despite not always needing urgent treatment. Staff ensured this patient was referred to appropriate teams to held manage vulnerabilities.

Staff mostly ensured that curtains were closed when supporting a patient, however there was one cubical where two beds were placed with no curtains to ensure dignity had been maintained, this had been discussed during the inspection and the service acted on this by removing one of the beds, but the cubicle still did not have curtains.

Staff did not always maintain privacy when speaking with patients. The service used navigators within the waiting room to signpost patients to the most appropriate part of the service. However, the navigator spoke to patients who were inside the waiting room which meant other patients could overhear conversations about why patients had attended the department which was not private or dignified. For example, one patient attended the department due to very private healthcare concerns; however due to the noise in the waiting room they had to speak very loudly regarding why they had attended the department. We spoke with this patient who told us this situation had upset them and they felt a total lack of privacy at this time.

Patients said staff treated them well and with kindness. We spoke with both children and adult patients, and they stated they were happy with the care they had received, and staff were kind and compassionate. Patients stated that staff listened to how they were feeling.

When speaking to patients who were receiving treatment the patients told us that they were happy with the care and treatment received. Patients told us that staff were kind and caring.

Staff delivered care in a non-judgemental manner.

We observed staff caring for patients who spent time with them to understand their concerns. Staff ensured individual needs were met, including medication, food, drinks, and access to personal care facilities.

Emotional support

Staff did not always provide emotional support to patients, families, and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood patients' care needs and wellbeing and were able to give the patients emotional support and advice when this was needed.

The department had access to older the person assessment and liaison (OPAL) team, the vulnerability team, and the psychiatric team to ensure patients who were vulnerable received the support that was needed.

Staff did not always support patients who became distressed in an open environment and help them maintain their privacy and dignity. Staff supported patients when they became emotionally distressed, however they did not always consider the use of available facilities, such as the mental health room or family room, to maintain privacy or dignity.

Urgent and emergency services

Staff did not undertake training on breaking bad news; however, staff could demonstrate empathy when having difficult conversations. When speaking to relatives who had been called to the hospital due to deterioration in a loved one's health, they told us that everything had been explained to them relating to the current situation of the patient and what the outcome could be, they stated that that this was clear, and they were able to ask any questions they had.

The service told us that nursing staff did not complete any formal training on delivering bad news. However, doctors received this through medical school, post graduate exams and during clinical placements.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients and relatives told us that they had been kept informed of the care and treatment they were received. People we spoke with told us information was also given to the patient's and family in a format they were able to understand.

Patients and their families could give feedback on the service and their treatment. The feedback from the ED survey was mixed. The service had a patient experience task and finish group; however, these recent results had not been published yet and we reviewed 2020 published survey data which showed a total of 286 patients participated in the survey. These showed UHB (University Hospital of Birmingham) had 1 question with a lower score than most other Trusts in 2020. This question was: 'After leaving A&E (Accident & Emergency), was the care and support you expected available when you needed it?'

Patients and relatives or carers could leave feedback on the NHS patient choices website. We saw positive feedback from people who had visited the department in 2023 which highlighted exceptionally caring staff and a professional and warm approach from all staff. Feedback reflected patients felt as if they had been treated with dignity; and information was clearly explained to them. This feedback was reflective of both the adult and paediatric service.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services for the local population, however system wide problems with accessing appropriate care and treatment meant more patients attended ED than it was designed for which meant patient delays. To manage this, leaders worked with the wider system including the local NHS ambulance trust to develop ways of working to support flow and manage patients.

Urgent and emergency services

At the time of inspection, we witnessed doctors visiting patients to complete observations while they were waiting on ambulances, due to not having enough beds. We also witnessed patients being supported to use the toilet and offered food and drink whilst waiting with paramedics.

The service had navigators situated in the waiting room of the department. They moved around to see patients and triaged patients to ensure that patients who required more urgent treatment were seen as soon as possible.

The service also used an ambulance decision area (ADA) and hospital ambulance liaison officers (HALO) in collaboration with the local NHS ambulance trust to support the department to ensure that patients have a positive journey when attending the department. The ADA and HALOs worked to ensure that patients waits in the department were as short as possible.

The GP (General Practitioner) services operated 7 days per week at each site with variable appointments as per the site requirement. For this site there were 36 daily appointments to see a GP.

The service had a family room where relatives could wait whilst their family member was receiving treatment. This room was also used for families to hold a private conversation with doctors, although not all staff used this when having private conversations.

The service had identified that the lifts to the floor where part of the minor injuries unit was located had been broken for some time. This meant patients with mobility issues use a longer route to find an alternative lift.

The department had suitable seating in the waiting room, however, for long periods of times during the inspection the waiting room was extremely busy and overcrowded. At some points patients were not able to have a seat due to relatives also waiting with patients.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The service had access to the psychiatric team 24 hours a day 7 days a week.

Staff had access to a mental health room to enable patients presenting with acute mental ill health to have discreet assessments and treatment where required. However not all staff were aware of this room or its purpose, meaning some patients were seen in less suitable areas. For example, staff saw patients in an eye room and a plaster room.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

The service was not always inclusive or took account of patients' individual needs and preferences.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. The department had the support of the vulnerability team who supported patients with learning disabilities, autism, dementia, and patients with mental health care needs. This included the provision of tools which supported staff, including hospital passports, and therapeutic observation booklets.

However, the service did not meet the Accessibility Information Standard, which had been a legal requirement since 2016. The AIS states health and social care services have to communicate with patients who have alternative communication needs in a way they can understand. The service had an action plan in place to address this however there was limited understanding of this by staff. For example, staff told us they had a communication box to help support patients who required communication aids, however this could not be located.

We noted that an email had been circulated by the vulnerabilities team to ask all staff to complete accessibility information standard training (AIS).

Patients could reach call bells and staff responded quickly when called.

The service did not have information leaflets available in languages spoken by the patients and local community. There were no information leaflets in languages for patients who did not speak English as their first language visible within the department.

Managers mostly made sure staff and patients, loved ones and carers could get help from interpreters; however not all patients with sensory impairments could access interpreters. The service had an interpreting service Monday to Friday 8am to 4.45pm, which provided a service for a limited number of languages. For languages not covered by this service and for out of hours requirements, interpreting services could be found on the intranet.

We spoke with a Deaf patient, who had British Sign Language as their first language, who had not been provided with an interpreter. Therefore, staff used a family member to interpret to the staff. They told us they had not been asked if they would like to access an interpreter who could sign for them. This is outside of national guidance and trust policies as family members are not trained to interpret medical information and it puts vulnerable patients at risk of continuing abuse or harm.

Access and flow

People did not always receive prompt care and treatment in line with national performance targets. However, patients could access the service when they needed it; and we acknowledge that compliance with national targets is a significant concern across most Emergency Departments at present.

Not all patients received treatment within agreed timeframes and national targets. However, managers monitored waiting times between February and April 2023 to drive improvement. The national target for patients to be triaged after arriving in the department was 15 minutes. However, the average time to triage time was 64 minutes. Managers had developed action plans to manage this.

The service monitored the percentage of patients in the department for over 6 hours. The national standard is 'Total Emergency Department Time' (TEDT) of 95% of patients having their emergency care completed within 6 hours of arrival in an Emergency Department. 'Data from the trust showed 34.9% in February 2023, 35.6% in March 2023 and 34.3% in April 2023 spent more than 6 hours in the department.

NHS England trusts have a performance target of 95% of patients waiting less than 4 hours between attending Emergency Department and a decision being made about their onwards care, such as admission, or discharge. The percentage of patients who were within the 4-hour target was 49.4%in February, 45.3% in March and 47.9% in April 2023.

Urgent and emergency services

The percentage of admissions waiting 4-12 hours from decision to admit were 43.4% in February, 44.6% in March and 43.2% in April 2023'

During the inspection there were patients waiting on ambulances for up to 4.5 hours whilst a bed to became available within the department.

The service monitored ambulance wait times between 27 March 2023 to 26 April 2023, during this period 2041 patients were bought to the department via ambulance. There were a total of 507 patients that did not meet the 30-minute hand over time, this equated to 24.8%.

The service had hospital ambulance liaison officers (HALO's) who were based at the ambulance entrance situated within the emergency department. The HALO role is to work with the ambulance crew staff and the department staff to reduce the ambulance waiting time at the department.

The service used a navigation system, where trained staff reviewed patients as they arrived to direct them to the most appropriate area such as being kept in the Emergency Department, being sent to the minor injury area, or being sent for a GP appointment on site.

The data we had received reflected that between December 2022 and January 2023, and selected from 150 patients' information there were 6% of patients that were moved on to other services.

The service had worked collaboratively in partnership with an ambulance service to introduce Ambulance Decision Areas (ADAs) within the service to support the system and reduce the delays in offloading ambulance patients.

The ADAs had 10 beds for patients. Two paramedics and 2 health care assistants from the local NHS ambulance trust staffed this. Even though the service was within the department it was still overseen by the trust, and there was a criterion of what care and treatment could be provided.

The service had a "PUSH" model in place to enable patients to be accommodated in the correct departments after being seen in the urgent and emergency department. However, staff told us that they did not know the PUSH model, and felt this process did not work, which meant that patients could stay in the department for longer than required.

The number of patients leaving the service before being seen for treatments was higher than the national average. Data received following the inspection showed 12% of patients between December 2022 and January 2023 left the department without being seen. The national average for 2022 was 6% as identified by the King's Fund emergency care data.

For the month of January 2023, a review looking at all patients over the age of 16 attending the Emergency Department with acute mental health ill health found 23% of patients left the department without seeing a nurse or doctor. This was higher than the trust average for patients, including those attending for physical health reasons. Since the inspection, the department have started a 7-minute briefing, which they deliver to staff every morning and this highlights areas for improvement, standards of care and staff responsibilities.

The department have support from a third party trust and who are responsible for providing the psychiatric liaison service. The data we received post inspection for this hospital between December 2022 and February 2023 showed that the department did not always meet their own target for patients be seen by liaison psychiatry. However, due to demands on this service they were not able to always deliver the service as expected which impacted on patients attending the department.

The average time from referral by an ED clinician to being seen by liaison psychiatry was 87 minutes, which was over the trust target of one hour.

The average time to be seen by a psychiatrist or equivalent following review by a mental health nurse was over 6 hours which was outside the trust target.

Trust audits showed several instances of delay of referral to liaison psychiatry when patients were not medically fit for discharge such as patients who were intoxicated, or awaiting outcomes of blood results or CT scans.

During January 2023, the number of patients admitted to the psychiatric decisions unit, or mental health ward at a specialist mental health NHS trust was 6. The waiting time for a bed was 18.5 hours.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns. We reviewed two complaints and their outcomes. The trust had investigated them, and gave an apology if this had been required, the complaints identified any failings by the department, there had also been additional contact information if the patients had further questions. Information was provided on how to contact the Parliamentary and Health Service Ombudsman if patients were not happy with the outcome of the complaint.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. In the patient experience group which had been held on 19th April 2023, 55 complaints from across sites and including acute medicine and SDEC were reviewed'. The themes were: considerable waiting times to be seen, access to phone chargers, broken vending machines, lack of food and water, pain relief whilst waiting to be seen, communication and irregular updates, privacy, and dignity concerns.

We reviewed 2 complaints the service had received and the responses to these. Managers responded to patients or their families by letter which clearly outlined the investigation findings following the complaint. Managers used the letter to apologise for the care the patients had received whilst been treated at the hospital.

Managers shared feedback from complaints with staff and learning was used to improve the service. Speciality level meetings were held where themes and trends were reviewed by the division 3 patient experience group and preventing harm team, as well meetings where themes and trends from incidents and complaints/patient feedback were reviewed. These were discussed and reported into the divisional board.

Staff told us that if a complaint had been about them then they received support from their line manager.

Urgent and emergency services

In the patient experience group, which had been held on 19 April 2023, 55 complaints were reviewed; the main themes were:

- Considerable waiting times to be seen,
- Access to phone chargers
- Broken vending machines.
- Lack of food and water
- Pain relief whilst waiting to be seen.
- Communication and irregular updates
- Privacy and dignity.

The group also looked at the following positives,

- Staff attitude
- Communication re treatment plans/ expectations

Staff could give examples of how they used patient feedback to improve daily practice. Complaint themes were reviewed for each site and changes had been implemented in response to themes. For example, concerns were raised about the length of time to get through on the telephone to nursing staff. As a result of this a trial had been undertaken where a communication team was set up to facilitate the timeliness of calls into the Emergency Department.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Not all leaders were visible in the service for patients and staff. However, local leaders had the skills and abilities to run the service. Managers supported staff to develop their skills and take on more senior roles.

Local leaders had the skills, knowledge, and experience to run the service. The local management team consisted of a triumvirate which was made up of a trust wide general manager, a local matron, and a local medical lead for the service. They were supported by a service manager and an operational manager on site. The local management team were supported by divisional leadership who oversaw the division and linked into the executive team at the trust.

Staff told us that they did not see, or in some case know, who the senior leaders of the division were, and that they were not visible within the service. The service had recently appointed a new matron; staff told us the matrons were supportive, approachable, and visible.

During the inspection we spoke with several staff who had recently received a promotion within the service. They informed us they had received support and development from local leaders to help them gain these new roles.

Urgent and emergency services

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust strategy to deliver its vision “Our Strategy to Build Healthier Lives” was developed following the merger and set out the trust’s shift from a single site to a multi-site organisation to being a key partner as part of an integrated health system with 9 supporting strategic aims.

At the launch, the strategy was disseminated to all staff through several meetings, including the trust’s monthly all staff Team Brief.

The strategy had also been shared with staff on their website. The strategy was available to staff in a number of different formats including the full strategy document, a summary of the trust’s priorities and a short video explaining the trust’s strategy.

New staff were introduced to the trust’s strategy and its underpinning vision and values as part of the corporate induction.

Culture

Not all staff felt respected, supported, and valued. However, staff were focused on the needs of patients receiving care.

During the inspection, some staff told us that they felt supported, that they could talk to their direct line managers, and they felt respected and valued. However, some staff told us that there was not a positive culture whilst working night shifts.

The service competed a staff survey which covered several areas including diversity and inclusion, raising concerns and development. The service stated that they were currently looking at the actions to improve culture following this recent survey. These would be implemented following May 2023.

For survey questions around diversity and inclusion, the service did not meet any of the targets they had identified. However, for ‘not experienced discrimination from manager/team leader or other colleagues’ which the target was 90%, this was met by 88% of staff responses received.

For inclusion and "I feel a strong personal attachment to my team” the score was 59% against a trust target of 60%.

For development of staff, all questions asked on the survey met the trust’s targets, which identified that staff feel they are developed within the workplace.

The service had access to the freedom to speak up guardian, however not all staff understood this role and the purpose of it.

Governance

Urgent and emergency services

Leaders did not always operate effective governance processes throughout the service and with partner organisations.

Not all staff were clear about their role and legal requirements when safeguarding patients, in part due to poor safeguarding training compliance. We found that there were 193 missed opportunities to raise both children's and adults' safeguarding referrals, and 88% of safeguarding risk assessments had not been completed. This meant that both children and adults could have been placed at risk, and not gained any support they required from outside agencies including local authorities and police.

The service completed an action plan once these concerns were raised. However, at the time of writing this report assurance still has not been gained about the safeguarding of children and referral to external agencies. Conditions were placed on the trust's registration to demonstrate compliance with regards to staff training and understanding. Furthermore, the trust was asked to evidence improved compliance with protecting patients and those linked to patients through timely safeguarding, and other third-party agencies referrals.

The service had implemented an action plan in relation to mandatory training, due to figures being low. However, the action plan did not have a date to identify when this had been put into place or dates of when the actions were to be completed by and there were not any colour codes on the action plan to identify which actions had been completed and which still needed to be completed. Training had also been identified in the hospital's previous CQC report identifying staff must be up to date with training.

The service had low appraisal rates; at the last inspection we told the service they should ensure that appraisal rates were improved. Appraisals rates were also identified in the previous report stating all staff must have yearly appraisals. We found this was still a concern on this inspection.

During the inspection we observed staff not adhering to infection prevention control procedures, for example staff were wearing masks under their chins and were wearing long sleeves. This meant that staff were not following the process for the service, this had also not been addressed by the senior staff in the department, which is potentially placing patients at risk of cross infection.

Governance of the service was discussed within speciality specific governance meetings. Meeting minutes were provided post inspection. Local leaders held triumvirate management meetings and band 7 staff meetings. We were not provided with any meeting minutes for other non-senior staff in the department. Local managers were able to escalate information up through divisional quality and safety meetings. We saw items on the quality and safety meetings included the risk register, clinical governance, and patient safety reports.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. Systems to manage risk, issues and performance were not always effective. However, leaders knew the significant risks and tried to reduce their impact.

The service had a speciality specific risk register in place. This also identified the description of risks, how significant or likely risks were to have impact and any control measures to mitigate risks, this also showed the date the risk had been added to the register and the date of completion. The risk register did not identify who is responsible for the identified risks. However, following the inspection leaders told us "as per the trust risk management policy, each risk must have a nominated Risk owner and risk lead. These are mandatory field in the Risk assessment form on our datix risk management system.

The risk register identified 11 risks within the department. The most significant risks were patients' waiting times on ambulances, and the priority to see patients, staffing and overcrowding in department and the management and high volume of patients presenting with acute mental illness was also identified. These risks matched our findings during the inspection.

Safeguarding of patients attending Emergency Department had been identified as a risk in January 2022, but this was removed in June 2022. However, we identified concerns relating to safeguarding training and the assurance of completing safeguarding referrals through intelligence prior to and during the inspection. Therefore, despite no longer being regularly reviewed as a risk this was still present, meaning vulnerable patients were at risk.

The service had a process in place for the shortfall of nursing and medical staff, and divisional leaders had oversight of this across the trust. However, despite this process and oversight, nurse staffing was not sufficient to keep patients safe.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff had access to the intranet where they could access policies and procedures to support them in their roles. Information governance training was included in the trust's mandatory training schedule.

The service had collected data and analysed this; this had been discussed in quality meetings, audit processes and quality improvement projects.

Engagement

Leaders engaged with patients and staff.

Staff had the opportunity to participate in a staff survey. The service was in the process of developing an action plan from the survey results and in addition to this an ED staff engagement forum was to be set up for May 2023.

Senior leaders told us that they completed a walk around of the department, where they supported and engaged with staff. However, some staff told us that they do not see the senior leaders in the department.

Managers planned improvements following engagement with patients. As a result of trends from complaint themes, a task and finish group had been started to improve patient experience across the emergency departments. Key themes included food and drink provision, communication, and information sharing.

We reviewed data from the ED Friends and Family Test (FFT) feedback where patients can say if they would recommend the service to their family and friends. For January 2023, the positive score was 80% and for February 2023 it was 81%. The service used these scores to identify learning to make changes within the department.

The service started an urgent and emergency care project in March 2023 because of the outcome of the patients' survey. The group's aim was to improve patient experience. The next audit will be available in 2023, the last data we received covered the review of 2020.

Urgent and emergency services

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Information relating to training had started to be implemented within the department in their 7 minutes briefings.

Data from the trust showed where audits had driven improvements. For example, staff completed an audit for pain management within the Emergency Department for 21 December 2022. Following this audit, clinical educators based within the department developed specific training about pain management to deliver to triage nurses and as part of a trauma support practitioner support course.

The service was committed to improving patient experience. For example, a working group had an action plan to improve waiting times, cleanliness, comfort of chairs, access to food and drink, access to telephone chargers and attitude of staff members.

The service also looked at trends identified from complaints; a working group had been working to improve patient experience across the emergency departments. This group's aim was to focus on key themes such as food and drink provision, communication, and information sharing.

An assurance process for patient safety alerts was established in July 2020. Information was presented to quality meetings and the trust board quarterly. The assessment included a review of audits and documentation to demonstrate processes were in place as well as a review of the incidents. Once assurance /audits were established these were monitored and any non-reassuring results were followed up by monthly reporting and continuous monitoring.

The service had identified a need to conduct spot checks relating to pain audits which drove the implementation of additional staff training.

Queen Elizabeth Hospital Birmingham

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Description of this hospital

The Queen Elizabeth Hospital Birmingham (QEHB) is part of the University Hospitals Birmingham NHS Foundation Trust which is one of the largest teaching hospital trusts in England, serving a regional, national, and international population. The hospital is a 1,215 bed, tertiary NHS and military hospital in the Edgbaston area of Birmingham, situated very close to the University of Birmingham. The hospital provides a range of services. The hospital has the largest solid organ transplantation programme in Europe. It has the largest renal transplant programme in the United Kingdom, and it is a national specialist centre for liver, heart, and lung transplantation, as well as cancer studies. It is also a regional centre for trauma and burns.

We carried out unannounced inspection on the Urgent and Emergency Department, the Cancer Service and Neurosurgery service due to information of concern being raised.

Following our inspection, under Section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to the regulated activity, Treatment of disease, disorder or injury. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to safeguarding within the 3 Emergency Departments (EDs) across the trust.

Urgent and emergency services

Requires Improvement  

Is the service safe?

Inadequate  

Our rating of safe went down. We rated it as inadequate.

Mandatory training

Not all staff completed mandatory training within set timescales. However, the service provided mandatory training in most key skills including the highest level of life support training to all staff.

Staff did not always complete mandatory training within set timescales. Staff did not meet the target compliance rates for several mandatory training modules. This included conflict resolution, fire safety (except for medical secretaries) and health and safety and welfare.

Topics where the department did better in relation to training compliance included manual handling theory, resuscitation awareness, corporate induction, and safeguarding level 1.

Compliance rates provided by the trust for manual handling theory was 98%, IPC level 1 was 81% and resuscitation awareness was 98%.

Each band 7 nurse led a team of staff and was provided with administration time to ensure mandatory training was up to date. Additionally, each department ran training days to cover mandatory training which was not covered online.

Leaders told us that across the nursing workforce there was one senior nurse advanced paediatric life support (PLS) trained member of staff at the QEHB site. The hospital Emergency Department (ED) policy was that they did not treat children under 16 years old, except in life threatening situations.

A paediatric educator had been recruited to support the senior nursing staff to rotate over the Heartlands and Good Hope paediatric EDs. Leaders told us there were medical staff trained in advanced paediatric life support (APLS) on every shift.

Areas where the hospital needed to improve their compliance included European Paediatric Advanced Life Support (EPLS) and Advanced Life Support (ALS) training (2 emergency nurse practitioners' training had expired), in the A&E department 22 had expired (3 were in date) and on the A&E ward 12 had expired (6 were in date).

Medical staff attended sepsis training at the time of their induction. Nursing staff, including agency staff completed an induction prior to starting any clinical work. Part of this was to complete the National Early Warning Scores NEWS2 module which included sepsis screening. There were sepsis policies and guidelines in place and staff were aware of them.

Clinical staff were provided with training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia, however, compliance rates were very low. For example, only 1 staff member had completed the Oliver McGowan training on learning disability and autism. Since July 2022, all registered health and social care providers have been required to provide training for their staff in learning disability and autism. Only 2 staff had completed mental health awareness and 0 staff had completed learning on understanding dementia.

Leaders told us it had been a challenge to improve compliance around the Oliver McGowan training. To rectify this, it had been agreed that the final part of the vulnerability's awareness module would include training on autism and learning disabilities; and for compliance to be monitored by the trust's education team.

Security staff working at the hospital were not directly employed by the trust. Leaders told us that due to the nature of the role and the complex nature of the patients, security staff were provided with training on safeguarding, suicide intervention, dementia awareness, as well as mental health first aid training by their employer.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed mandatory training both online and in person and the trust had clinical educators in place. Topics on which training was provided included conflict resolution, health, safety and welfare, information governance and safeguarding children and adults. We saw that a band 7 educator had a live spreadsheet with a course trajectory for each member of staff and had details such as what was outstanding, booked and what had been completed.

Clinical educators were in place who monitored staff training and alerted staff when they needed to complete this. Managers were able to access information around training compliance rates. However, we heard that training would sometimes be cancelled or staff could not always complete training scheduled due to staffing issues. There was a newly implemented mandatory training action plan in place, however, none of the actions had yet been completed or achieved.

Safeguarding

Not all staff were up to date with required safeguarding training. Data showed not all staff knew how to make a safeguarding referral.

Target compliance rates were not met for some staff groups for safeguarding adults and children level 2 or level 3. This meant not all staff were trained in line with the intercollegiate documents; 'Adult Safeguarding: Roles and Competencies for Health Care Staff' and 'Safeguarding Children and Young People: Roles and Competencies for Health Care Staff' as produced by the Royal College of Nursing.

Staff did not always have access to staff trained in safeguarding adults or children to level 4 for additional support or advice. Leaders told us level 4 trained staff were based within the trust safeguarding team, which was a separate team to ED. However, there was no cover for level 4 at weekends or out of hours.

The hospital safeguarding team visited the ED daily. Staff from the safeguarding team supported in areas, such as reviewing incident reports, delivery of teaching sessions, completion of deprivation of liberty applications and completing mental capacity assessments.

The children's safeguarding team reviewed all attendances to ensure safeguarding referrals had not been missed. None of the safeguarding teams worked out of hours, however, they had been covering bank holidays to support clinical teams.

The trust had a paediatric liaison service (PLS) team who reviewed patients who had attended the department. The role of the team was to review daily admissions of patients under 18 year's old. As part of the review the team had identified where there were attendances where there may have been a safeguarding concern and to ensure safeguarding policies and procedures had been followed.

Staff we spoke with during our inspection were able to explain how they would make a safeguarding referral. During the inspection we saw staff had completed safeguarding referrals. However, data from the trust showed a number of opportunities to safeguard patients, particularly children, were missed. Data from quarter 4 (2022/23) showed out of 829 16 to 17-year-old attendances reviewed, there were 25 (3%) missed safeguarding opportunities, as well as 109 CP-IS (The child protection-information sharing service) checks missed.

The PLS team had an action plan in place which included reporting on steps taken to improve compliance and reviewing mental health presentations in the department to look at why they had not been completed. Mental health and assault were a consistent area of concern where referrals were missed.

Information was displayed on what to do if a child was under the age of 18. This included actions, such as completing child protection information service (CP-IS), making a safeguarding referral if required, as well as requesting support if a child had mental health needs. Information on what to do if a child left the department without being seen was available for staff.

There was a children, young person, and adult restraint procedure in place. The procedure contained a restrictive practice guidance flowchart, identified types of restraint, and contained documentation to record a post restraint review.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always follow infection control measures. They kept equipment visibly clean.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). There was an 'Infection Prevention and Control' policy in place with links to other relevant policies. Staff had access to posters displaying information for staff on infection control and isolation guidance on contagions such as influenza, Methicillin-resistant Staphylococcus aureus and Carbapenem resistant Enterobacteriaceae (CPE). However, not all staff followed these trust documents.

Not all staff had completed their mandatory training for infection prevention and control; data showed 81% compliance for this training at the time of our inspection.

We saw poor infection control practices amongst staff. For example, we saw 3 doctors wearing watches and staff with no surgical masks. Staff told us some doctors wore long sleeves which was not in line with 'bare below the elbow' strategies intended to reduce the risk of infection transmission.

Hand hygiene audit results were poor, although had shown improvement. The latest results for March 2023 showed 50% compliance to effective hand washing principles, this had improved from 30% in February 2023. There was an action plan in place to improve the department's '5 moments of hand hygiene' and 'bare below the elbow' compliance.

We visited the laundry cupboard on two occasions and saw clean sheets on the floor, as well as patient gowns touching the floor. This meant clean laundry designed for patient use was not being stored in a way to prevent contamination.

We saw 3 sharps containers were overfilled. This meant there was a risk of needlestick injuries and subsequent infection transmission for staff. There was an Infection Prevention and Control Policy in place with links to other relevant policies.

The hospital had a team of housekeepers. The team completed any deep cleans and cleaning of patient areas, such as bed frames, curtain rails, toilets, and hand basins. The housekeeping team kept a log of the tasks they had completed. However, we saw a cleaning log in the patient toilets was not completed consistently.

Cleaning staff had a colour coded cleaning matrix to use following patient discharge or transfer. This contained information on different types of clean depending on the potential infectious status of the patient. For example, a 'green clean' required antibacterial wipes and a 'platinum clean' included a steam clean and curtain changes.

Equipment was visibly clean. We saw staff had used 'I clean stickers' on commodes in the sluice area.

Managers monitored infection prevention and control compliance. The department participated in the Royal College of Emergency Medicine (RCEM) infection prevention and control national quality improvement project March 2022. However, there were no action plans available to view. They also completed an infection prevention and control ward review assurance tool which included cleanliness. Results from February 2023 showed an average compliance rate of 82% overall. Recommendations including ensuring trolley bases were clean, ensuring the underside of chairs were cleaned and removing staff belongings from bays. This was not found to be an ongoing concern at the time of the inspection.

Environment and equipment

There were significant gaps in the recording of safety checks of specialist equipment. Patients did not always have access to call bells.

There were significant gaps in the recording of daily safety checks of specialist equipment. We found significant gaps in the checks around resuscitation trolleys including in minors, majors, and resuscitation areas. This had been raised on a previous inspection of the department. This was a potential risk to patients as lifesaving equipment such as airways and oxygen masks could be missing, broken, or expired. We issued the trust with a Section 29A warning notice in relation to this. Following the inspection, the trust took immediate action and provided an action plan and evidence of improvement.

Not all patients could reach call bells. Staff did not always ensure patients had their call bells within reach. We found that 5 patients on trolleys had not been given their call bells during the inspection period.

Equipment was portable appliance tested by an external contactor and the service had enough suitable equipment to help them to safely care for patients.

The design of the environment followed national guidance. The majors area had individual patient cubicles with doors that could be closed. There was a separate waiting /baby feeding area for children who came into the department. However, when we inspected the ED on 24 April 2023, there were adults sat in the area designated for children. This meant that children may be exposed to situations that were not appropriate for a child.

The environment was split into several areas including a waiting room, majors, minors, resus, and an ambulance decision area. Under national guidance, patients should not wait more than 4 hours to be moved to a different area of

the hospital after a decision to admit them has been made. However, we acknowledge the current pressures which meant often patients had much longer waits to be moved onto a ward from ED. Staff told us that there was not enough room to put a hospital bed if the patient needed to stay for over 6 hours. This meant patients were at increased risk of pressure damage.

The service mostly had suitable facilities to support patients. There was a mental health assessment room close to the patient waiting area. The area had 2 doors and an emergency call bell; however, 1 door opened into the staff only reception area. At the time of the inspection there was no risk assessment in relation to this. We raised this at the time of the inspection. Following the inspection, the trust completed a risk assessment form identifying mitigating actions, such as ensuring staff did not leave patients alone, that staff were aware of panic buttons, and that these were tested regularly and linked to security.

We reviewed an audit of the environment which took place in March 2023. The ED scored a performance rating of 94%. Where areas did not achieve 100%, actions were identified, such as making repairs and specifying certain areas needed to be cleaned.

Staff sometimes used another area for patients with mental health needs called fit to sit. This area had potential ligature points inside for example coat hooks. There was a relatives room if anyone needed a quiet space, for example if they had received bad news. The department had ligature cutters for staff to use if needed.

Staff mostly disposed of clinical waste safely. There were sufficient clinical waste bins in place for staff to store any clinical waste. There was a clinical waste policy in place however, the review date was dated as February 2019. We saw 3 sharps containers were overfilled.

Assessing and responding to patient risk

Staff did not consistently document risk assessments for each patient. When staff recognised patients were deteriorating, they responded quickly.

Staff did not always complete risk assessments consistently for each patient on arrival, using a recognised tool. There was a Manchester triage process in place. The triage nurses would allocate a triage category following the Manchester Triage guidelines. This allowed the nurse in charge, consultant in charge and anyone else to be able to see who was next to be seen by the clinicians according to a priority score.

There was information available for staff on what to do when patients had a high NEWS. The tool had information on the sepsis six, actions for triage and clinicians. There was an adult sepsis guideline in place which was up to date and version controlled. The guideline included a sepsis, deteriorating patient pathway. There was also a procedure for the escalation, management and monitoring of acutely ill adult patients using the National Early Warning Scores (NEWS2).

We requested sepsis audits and action plans, however, there were no audits of this type available. Following the inspection leaders told us they had recently rolled out a clinical dashboard for use in the ED. This will include sepsis data, missed antibiotics and repeat observations. Following the inspection leaders told us there was a sepsis group in place where audit outcomes were reviewed, and which were reported into quality groups. This allowed for the chief medical officer to have a high level of oversight of outcomes and performance in this area.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We reviewed 11 patient's NEWS2 and found all apart from 1 had been completed appropriately.

The trust's electronic recording system automatically created an alert for NEWS2 of 5 and above inviting staff to screen for sepsis if they had not already done so as part of their initial assessment. The alert had to be acknowledged by a member of the emergency team, which was time stamped and had an electronic trail.

We observed a member of nursing staff in the waiting area taking patient observations. Staff told us how 2 nurses were allocated to keep a check on the waiting areas. Reception staff told us they would press the emergency buzzer if they had any concerns around a patient in the waiting area when no nursing staff were present.

We reviewed 11 patient care records and found patient risk was not always recorded. We found gaps in recording around the assessment of pressure areas, assessment of nutrition and screening for sepsis.

Staff did not follow trust policies to minimise the risk of skin damage for patients waiting a prolonged time.

The hospital had a pressure area action plan in place. The plan included the introduction of hourly safety checklists for patients in cubicles which included repositioning and skin assessment. The timescale for implementation of this was August 2023. Other actions included reviewing the use of overlay mattresses on trolleys and formal assessment of the skin at agreed points during the patients stay in the department.

There was a pressure area care chart in place which noted staff to check skin within 6 hours. If the patient was found to have a pressure ulcer this was to be reported on the electronic recording system, alongside a risk score and considering a referral to the tissue viability nurse.

There was no hourly rounding in place to ensure patients were comfortable, hydrated and to ensure their skin integrity was checked. The policy was that a patient's skin integrity must be assessed within 6 hours of admission to the ED.

We reviewed a patient's record who had been waiting in the department for several hours. We found the patient had not had a skin assessment completed. The patient was diabetic with a high body mass index so was at high risk. We escalated this to the nursing staff at the time; we also needed to escalate that another patient was feeling discomfort in their pressure areas.

Staff assessed falls risks for patients in the department who were located on trolleys for prolonged periods. We did not see any individual patient risk assessments recorded around the risk of trolley rails while in the department. This was not in line with the trust guidance for the management and use of bed and trolley rails for adult inpatients.

The guidelines stated that an initial risk assessment must be carried out by the registered nurse caring for the patient on admission and following patient transfer, prior to the use of bed rails. The policy makes it clear that although bed rails were also often referred to differently, such as side rails and safety rails that the guidelines would be referred to as bed rails.

Staff told us how they ensured any patients who were at high risk of falls were placed in visible cubicles. Registered nurses used their professional judgment to assess if patients were safe on the trolleys and that if the nurse had any concerns, they could make any reasonable adjustments.

The bed rail policy stated bed rails must be used at all times if nursed on a trolley, it also advised that for patients showing confusion, an enhanced care risk assessment should be undertaken to identify the level of supervision required whilst a patient was being nursed on a trolley with bed rails in the upright position. At the time of the inspection leaders told us there had not been any falls incidents relating to patients climbing over the trolley rails.

Staff followed a process chart that was in place for post falls care in the department. The care included a review by the doctor, commencing neuro observations and documenting.

Staff participated in safety huddles at handover where topics of risk, including any incidents and learning were discussed.

We observed how staff managed a trauma patient that had attended the department when a pre alert had been received. We saw a full trauma team was present, good management with timely scans and appropriate interventions.

We observed several emergency buzzers (that staff activate in a medical emergency) being activated during the inspection. Staff responded quickly and dealt with the emergency situations appropriately.

Not all patients assessed as requiring 1 to 1 supervision or care were provided with this. On 1 occasion a patient with mental health needs who was known to be at risk and who had 1 to 1 support was left alone for a short period of time and an incident occurred. This was escalated as a concern by senior staff at the time. However, we observed other patients having 1 to 1 care throughout the inspection as per risk assessments.

There were various trust and local guidelines in place to support staff while managing/resuscitating sick patients. These included guidance on cardiac arrest care, cardiopulmonary resuscitation bundles, fluid balance and monitoring. There was also a draft emergency CT scanning guideline in place which was under review.

There were separate children transfer policies for each hospital site in view of the paediatric services available. Sick children from the hospital were transferred to the local children's hospital. There was also a sick children's transfer team in the West Midlands.

Staff arranged risk assessments for patients thought to be at risk of self-harm or suicide. The department worked with the psychiatric liaison team 24 hours a day 7 days a week.

There was a mental health screening assessment tool in place. Staff used this to identify if a patient may be at immediate risk of harm to themselves or others and included a suicide risk screen. The assessment was colour coded with red responses indicating a high risk and requiring a mental health assessment by the Rapid Assessment Interface Discharge (RAID) team.

There was a ‘therapeutic and observation engagement’ document in place that assessed individual risks to patients who presented with symptoms of mental ill health. We observed staff had completed the document for one patient and were completing 15-minute observations as a result.

Shift changes and handovers included all necessary key information to keep patients safe. We observed comprehensive medical and nursing handovers.

Staffing

Nurse staffing

The service used agency staff to make sure they had enough nursing staff and support staff with the right qualifications, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

The ED had a vacancy gap of greater than 30%, therefore it relied on bank and agency staff to support safe staffing across the service for nurses.

At the time of the inspection, we found there were adequate levels of staff in line with the safer staffing tools used. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Staffing ratios were calculated based on The Royal College of Emergency Medicine guidance.

Six monthly workforce reviews were undertaken which included acuity and attendance information to ensure service demand was incorporated into up-to-date requests for workforce planning.

The department manager could adjust staffing levels daily according to the needs of patients. There was a mechanism in place for a helicopter nurse on each shift to help in areas they were most needed and a policy in relation to this. Helicopter nurses supported the staff on shift and were used to help out in different areas as needed.

The service had reducing vacancy rates. The trust had been working to improve their vacancy rates; for example, reducing band 5 vacancy rates from 54 vacant posts to just 4. The matron had clear oversight of the workforce.

There were 5 band 6 nursing vacancies, 5 band 7 vacancies, 4 band 5 vacancies, 10 band 3 vacancies and 6 band 2 vacancies.

There had been a workforce review at the beginning of 2023 alongside the director of workforce and finance using an acuity model for the department. Recruitment and retention plans were in place.

The service had high sickness rates. Data showed a sickness rate of 7% for A&E ward staff, 4% for A&E dept and 6% for emergency nurse practitioners over the last 12 months.

The process was that the band 7 team managed the sickness and the matron had oversight. The matron managed all band 7 sickness.

The service had high turnover rates. Data showed that the average turnover percentage for nursing and midwifery registered staff over the last 12 months was high at 15%.

A bespoke emergency department education strategy had been developed and a professional nurse advocate (PNA) offer was available within the emergency department.

The role of the PNA and use of A-EQUIP model (advocating for education and quality improvement) was in place to facilitate support using restorative clinical supervision.

The service had high rates of bank and agency nurses. Data from April 2023 in relation to both qualified and unqualified nursing staff groups showed there were 635 agency filled shifts and 504 bank filled shifts. Agency shifts were authorised a month in advance to optimise the fill rate.

Managers used bank and agency staff that were familiar with the service. Each site had a cohort of agency staff who worked regularly within the departments. This helped to mitigate the skill mix risk due to local leaders having an awareness of the capabilities of the agency staff assigned.

Managers made sure all bank and agency staff had a full induction and understood the service. There were local inductions in place for all staff including nurses, students, and agency nurses. New nursing staff had a 6-week set programme to complete which included topics, such as trauma and resuscitation.

Medical staffing

The service used locum staff to ensure there were enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, there were not always enough speciality registrars overnight. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service used high numbers of locum medical staff to keep patients safe. The service had high rates of bank and locum staff. Data for April 2023 showed that locum medical fill rates averaged around 18 locums covering shifts each day.

The consultant workforce at the trust included 48 consultants, some of which worked across sites. At the time of the inspection the arrangements were one consultant present from 8am to midnight. There was a senior decision maker (junior doctor in their fourth year of training and above overnight, until 8am). The consultants were on call overnight to come into the department if required.

To meet the target of 1 whole time equivalent (WTE) per 4000 patients the trust would require an extra 50 consultants across the trust; the risk was identified in the department risk register.

The actions identified to mitigate the risk included locum cover, prioritising the most experienced staff to night shifts and development of a strong educational and development programme to aid recruitment as well as rolling recruitment. Key actions remaining included a department full business case and a rolling recruitment campaign going out for an additional 8 consultants when local trainees finished their training.

Leaders told us they maintained safe staffing levels for medical staff using regular locums and through utilising GPs with special interest as middle grades covering the rota gaps.

There were not always enough speciality registrars on nights. We reviewed the staffing levels during the inspection and found that only 1 night out 7 had the planned number of 4 speciality registrars and 6 nights had 3.

At the time of the inspection the trust was actively working to improve their recruitment strategy and had interviews planned for May 2023. The trust had also taken the international trainee fellowship programme initiative to help improve any rota gaps.

The trust was working towards expanding their advanced clinical practitioner and emergency nurse practitioner workforce.

The service had low vacancy rates for medical staff. The senior medical staff worked cross sites. Data showed there were 44.50 budgeted WTE junior medical staff and 46.50 actual WTE. There were 19.00 WTE budgeted senior medical staff and 17.86 actual WTE. The trust was producing a right size workforce paper and business case to affect the workforce required to meet the demands of the EDs.

The service had low turnover rates in medical staff. Data showed trainee medical and dental staff at QEHB had a turnover percentage of 7%. Non-trainee medical staff across all Emergency Departments had an average turnover rate of 6.52%. This met the trust key performance indicator of 9%.

Sickness rates for medical staff were low. There was a sickness rate of 0% for medical and dental staff in the last 12 months. The trust's key performance indicator for sickness was 4%.

Managers made sure locums had a full induction to the service before they started work. There was an induction program in place for junior staff which included areas such as a department walk through and information technology training. Senior house officers were paired with a registrar on their first clinical shift. A senior house officer is a junior doctor who is at least 1 year post qualification.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The majority of patient records were electronic. The small amount of paper records were clear and legible.

All information needed to deliver care and treatment was available to relevant staff in a timely accessible way. Staff had enough computers to access patient records when needed. All records we reviewed were signed and dated.

Patient records included relevant information, such as information on the patient's mental health and physical health needs. However, we did find some gaps in recording in some patients' electronic records.

Records were stored securely. Computers were password protected and easily accessible for staff in the department. Paper notes were kept in cabinets at the nurses' station.

Medicines

Medicines were not stored or managed safely, and there was no policy or guidance for the use of rapid tranquilisation. However, the service generally used systems and processes to safely prescribe and administer medicines.

Medicines were not stored or managed safely. Medicines storage was mainly locked and secure with access only to authorised staff. However, medicines within these areas were visibly disorganised with loose strips of medicines not in their original containers, tablets and liquid medicines stored together with no coordinated system in place to easily locate a medicine. We also saw gaps in recording of fridge temperature checks in the ambulance decision area.

There was a lack of individual staff responsibility to ensure that medicines were stored in an ordered way. This increased the potential risk of a medicine error, or a medicine not being located. The latest 'safe and secure handling of medicines' audit (October 2022) also identified areas that needed improving. Areas identified as non-compliant on the most recent audit included areas, such as ensuring key codes had been altered within the last 12 weeks and ensuring all medicines were within their expiry date.

We issued a warning notice on the 28 April 2023 due to the high risk of potential patient harm and immediate action was taken by the trust to address the issues identified.

Urgent and emergency services

Resuscitation medicines required in an emergency were stored in tamper-evident boxes, which follows Resuscitation Council (UK) guidance. Resuscitation trolleys themselves were not tamper- evident. It was therefore not clear how the trust ensured that equipment and intravenous fluids required in an emergency were safe to use. However, following the inspection leaders told us their Itray system was tamper evident and the fluids were contained on a sealed tray and it was easy to see whether this seal has been broken/tampered with.

Staff followed systems and processes when safely prescribing, administering, and recording medicines. The trust had their own in-house electronic prescribing and medicines administration (EPMA) system. It provided information in one place including the patient's medical requirements, a medicine history and up to date information on prescribing. Where dose adjustments needed to be made for weight-based medicine prescribing, the system alerted the prescriber and calculated the correct dose.

We were shown how the pharmacy team were able to order medicines urgently if needed. Staff knew the routes to obtain medicines out of hours if required.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. A pharmacist led service (7am to 11pm) based within the acute medical unit ensured that all patients admitted from the emergency department had a medicine history taken and reviewed. This included providing medicine advice and prescribing support.

Staff completed medicines records accurately and kept them up to date. Documentation of medicines administration including routes of administration and specific times of administration were completed on the medicine records reviewed. We saw an example where pharmacy staff had reviewed a patient on a high-risk medicine and the reason for pausing one medicine was clearly documented by the clinician.

Information on missed doses of medicines was not currently available for the emergency department, however, a quality indicator was being designed so that this information would be available for monitoring.

Allergy statuses of patients were routinely recorded on all medicine records seen. This meant that allergies were highlighted, and medicines could be prescribed safely.

Weights of patients were recorded on medicine administration records which is important for calculating weight-based medicines prescribing.

Controlled drugs (CDs) are medicines requiring more control due to their potential for abuse were stored safely and securely with access restricted to authorised staff. Checks were undertaken and recorded by 2 staff twice a day. Checks of CDs showed that they were within date and stock balances were accurate.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff undertook medicine history reviews and clinical checks on prescribing. This ensured patients' medicine records were up to date and accurate before they were admitted or moved between services.

Staff learned from safety alerts and incidents to improve practice. The trust had an electronic system for recording incidents and staff we spoke to were able to identify its use and how to access the system. Staff knew how to report incidents and gave us examples of what should be reported.

The trust had a Medicines Safety Officer (MSO) in line with NHSE directives. The MSO investigated concerns of safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents.

The service had no policy in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There was a 'Children, Young Person and Adult Restraint Procedure' (24 June 2022), however, there was no policy or guidance for the use of rapid tranquilisation which may be used where urgent sedation is needed for managing violence and aggression. This meant there were no clear guidelines on place to direct staff.

There was a medical gas store area which was external to the department but close by. The storage cupboard was key coded. Porters transferred oxygen cylinders to the ward and returned any empty cylinders to a main storage unit where they were collected on a regular basis.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff understood their responsibility to raise concerns, to record safety incidents, concerns or near misses and to report them where appropriate. We noted that an incident that happened during the inspection was reported on the trust's electronic recording system.

Managers debriefed and supported staff after any serious incident. We observed that following a patient requiring resuscitation the multi-disciplinary team had a hot debrief.

The service had no never events. There had not been any never events in the department over the last 12 months. Never Events are defined as Serious Incidents that are wholly preventable because 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.

Not all nursing staff understood what was meant by duty of candour. Four out of 6 nursing staff we spoke with about duty of candour were unable to explain what it meant. However, we saw leaders had completed duty of candour following an incident and that staff met with patients' families when things went wrong. Duty of candour means that health and care professionals must: tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong, apologise to the person (or, where appropriate, their advocate, carer or family) offer an appropriate remedy or support to put matters right (if possible).

There was evidence that changes had been made because of feedback. Learning from incidents was shared with staff through the 'Risky Business' trust newsletter. We reviewed Risky Business documents February 2023 and August 2022 which had been designed to help learn from each other's experience, to improve care for future patients and prevent errors. We found contents included clinical topics such as communication with families when a patient can't, equipment in the emergency department and lessons of the month.

We saw various examples of shared learning including a lesson of the month document around Acute Angle Closure Glaucoma its signs and symptoms, diagnosis and escalation and signposting to further information and support.

Urgent and emergency services

Staff spoke of being told about key messages but did not always feel they were aware of any shared learning in relation to incidents that had happened in the department.

Leaders held monthly morbidity and mortality meetings that fed into service improvement. We reviewed the morbidity and mortality meeting minutes dated January and February 2023 and saw case discussions took place which included looking at what could be improved.

Incidents were discussed at the emergency medicine directorate meeting. These included Duty of Candour compliance and root cause analysis investigations outstanding. The division 3 quality and safety meetings included incident themes and trends. The top 5 trends at the time of the inspection were patient falls, staffing issues, non-adherence to standards, pressure ulcers and medication issues. There were several delayed diagnosis incidents, including serious incidents, which led to the compilation of learning materials which were used for induction and teaching sessions.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. There were arrangements in place for reviewing and investigating safety incidents when things went wrong. Delegated staff completed serious incident reports when incidents occurred. Reports included details around duty of candour, root causes, contributory factors as well as action plans with deadlines for completion.

There were processes in place for responding to external safety alerts including a procedure for dissemination and implementation of central alert system alerts.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance, however, some policies were not up to date. The department followed British Thoracic Society (BTS) guidelines to manage asthma, chronic obstructive pulmonary disease (COPD), pneumothorax and chest drains. Leaders told us they had participated in a COPD management audit which led to a quality improvement project and educational package to improve quality of care.

National Institute for Health and Care Excellence (NICE) guidelines were followed in the management of head and neck injury and major trauma patients.

Peoples physical, mental health and social needs were holistically assessed delivered in line with legislation, standards, and evidence-based standards. Learning projects referenced research and NICE guidelines.

Sepsis screening and management was done effectively in line with national guidance. Patients who were frail or vulnerable could be referred to the Older Person's Assessment and Liaison (OPAL) team where their needs following discharge could be assessed.

The OPAL team took a proactive approach by reviewing patient lists and identifying suitable patients for the service. The service completed mobility assessments, liaised with care homes, and sought packages of care and had their own stocks of equipment.

There were policies, procedures, and guidelines in place such as those in relation to sepsis, safeguarding and infection control. Policies were version controlled and contained links to relevant guidance and legislation.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The department worked closely with the psychiatric liaison team.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Staff handovers routinely referred to the psychological and emotional needs of patients.

Nutrition and hydration

Staff did not always assess patients at risk of malnutrition. A catering team provided food and hot drinks at set intervals and specialist support was available if needed. However, there was no clear process for ensuring patients were kept hydrated between catering visits.

Catering teams provided patients with food and drink, however, there was no clear process for ensuring patients were hydrated between these visits. The catering team provided patients, including those in cubicles with hot drinks 3 times a day. They also provided them with something to eat if they had been in the department for longer than 6 hours.

There were no clear processes in place for staff to provide patients with a drink in between catering visits; it was down to the individual nurse looking after the patient to do this. This was important as some patients stayed a long time.

During the inspection we heard examples where patients had been in the department in cubicles for prolonged periods without being provided with regular drinks. This meant that we were not assured vulnerable or unwell patients were being provided with adequate hydration.

Lack of food and water was noted as a theme in the patient experience group report in April 2023.

The waiting area had vending machines where patients could purchase snacks and drinks. We also saw water was available for patients and their relatives in the department. Water was accessible to ambulance staff caring for patients on ambulances.

Volunteers told us they could make patients a cup of tea if they had made the necessary checks that a patient was safe to have one.

There were posters displayed for patients in main areas to say if they wanted a drink to ask the nurse in charge. However, not all patients were able to do this.

Leaders told us that a task and finish group had been set to improve patient experience and was underway with a focus on key themes including food and drink provision.

Staff did not consistently assess if patients were at risk of malnutrition. We reviewed 11 patient records and found the risk of malnutrition was only assessed in 4 of them.

Specialist support from staff such as dietitians and speech and language therapists were available at the hospital for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after it was identified they needed it, or they requested it. We reviewed 11 patient records and saw when applicable appropriate pain relief was prescribed in a timely manner. Staff completed patient pain scores in their records to assess pain levels. Staff offered pain relief at the point of triage or clinical assessment as reflected by the pain score and presenting complaint.

There was a pain management policy in place. Patients we spoke with felt their pain was managed appropriately. However, pain relief whilst waiting to be seen was noted as a theme in the patient experience group report in April 2023.

The emergency department educators were in the process of agreeing a teaching plan to deliver patient group directions (PGDs). PGD's are documents that permit the supply of prescription only medicines to groups of patients with individual prescriptions.

We reviewed an emergency department spot check audit for pain management dated December 2022. The audit assessed against several measures such as if the patient's pain been assessed, if analgesia was required, given and if pain had been reassessed. The results showed that out of 12 trauma alert patients, 10 had a documented pain assessment and 4 of these had pain reassessed at regular intervals. Of the 7 patients identified as having pain scores indicating analgesia required, 6 were given analgesia. Since the last audit educators had ensured additional focus was given to pain assessment during triage training and the trauma support practitioner course.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements, however, outcomes did not always meet national standards.

The service had participated in relevant national clinical audits. The department audited themselves against national guidance and participated in audits and quality improvement projects by the Royal College of Emergency Medicine (RCEM). RCEM quality improvement projects 2021/2022 included assessment for cognitive impairment in older people, fractured neck of femur and infection prevention and control.

The RCEM audit Assessing for cognitive impairment in older people, local report published in 2021 key findings included: _

- A cognitive assessment of patients ≥75 years using a validated tool whilst in the ED should be routine.
- A cognitive assessment with a validated tool should be considered in those aged 65-74 presenting with a non-minor injury complaint.
- There must be clear documentation of identified cognitive impairment and/or delirium to aid transfer of patient care.

- The current 'Silver Book (2012)' recommendations should be reviewed and updated.

The RCEM audit for FRACTURED NECK OF FEMUR published in 2022 key recommendations included: _

- Every ED should have a fractured neck of femur pathway and apply quality improvement (QI) methodology to improve; a. time to pain assessment, b. time to analgesia, c. time to x-ray and, d. time to fascia illaca block.
- Every ED should have nursing and medical leads for fractured neck of femur to champion the cause and steer improvement work.
- Every ED should use a behavioural pain scoring tool for patients with cognitive impairment.
- ED's to review effectiveness of Plan, Do, Study, Act (PDSA) cycles and engage all ED staff in this process.
- Triage nurses need to be supported and assisted in delivering timely and effective initial analgesia to any patient presenting with moderate or severe pain. This would form the basis of an important QI project in itself.
- Departments that have seen local improvements are encouraged to share good practices and submit case studies to RCEM.

The department had completed an audit in relation to chest drain insertion as per national guidelines. The audit resulted in a teaching package which was published in the RCEM learning resources in 2020.

Medical employees had completed a Scaphoid Pathway Audit. The audit looked at the scaphoid pathway, compliance, reasons for noncompliance, secondary objectives, and limitations. The department also completed some local audits such as those around infection control and safeguarding. This meant leaders could identify areas for improvement when needed.

There was an audit titled 'discrepancy between the A&E opinion and the reporting radiologist /radiographer'. The audit considered radiology standards as well as emergency medicine standards. This meant the trust were measuring themselves against current standards to drive any improvements for patients.

Leaders told us sepsis audits at the trust were completed by the identified lead consultant for sepsis in collaboration with an identified lead for sepsis. However, we requested the sepsis audits and action plans for Queen Elizabeth Hospital Birmingham and were told there were no audits of this type available. Following the inspection, leaders told us they had recently rolled out a clinical dashboard for use in the ED. This will include sepsis data, missed antibiotics and repeat observations. Following the inspection leaders told us there was a sepsis group in place where audit outcomes were reviewed, and which were reported into quality groups. This allowed for the chief medical officer to have a high level of oversight of outcomes and performance in this area.

At the time of the inspection, leaders were at the stage of collecting data for computerised tomography scan inpatients with a head injury. They had also completed the data for major trauma patients with major haemorrhage, tetanus and tetanus immunoglobulins. The recommendations had been shared with the team to improve the quality of care.

The department's unplanned reattendance rate within 7 days, which included any readmissions within 7 days of departure, was low at 7%.

Unplanned readmission rates within 72 hours for patients who presented in the department with chest pain were just above 2%.

The department provided a list of numerous projects aimed at improving patient outcomes including ones that had been newly identified. These included topics such as renal colic and point of care ultrasound.

Outcomes did not always meet national standards. However, when this was identified the department took action to learn and improve. For example, the trust aspired to achieve 15 minutes to electrocardiogram (ECG) for all ambulatory care patients presenting in the emergency department with non-traumatic chest pain and were working towards these indicators. At the time of the inspection the average time to ECG was 30 minutes. Leaders told us they were in the process of making changes to the ambulatory care patient pathway by moving patients into a separate area and having a dedicated team look after chest pain patients at the triage.

The report of the productivity and quality of care provided in ambulance decision areas at the trust which referenced a chest pain audit showed that between the 1 January 2023 and 31 January 2023 the average time from arrival in the ambulance decision area (ADA) to ECG was 28 minutes, down from 53 minutes the previous month.

A report had been complied by the trust's mental health group dated April 2023 which included an in-depth analysis to look at areas for improvement across the mental health pathway against the University Hospital Birmingham escalation document as well as a review of the 5 longest patient stays for each hospital site. Some recommendations from the report included clear documentation of the discharge destination of patients, clear dates and times of assessment completed by the psychiatric liaison team and discussing with the clinical service lead regarding patients being, medically fit for discharge and organic causes ruled out prior to referral.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Local audits were completed, and actions identified such as audits around safeguarding, the environment and infection control including hand hygiene. Audits were repeated if they did not meet the trust's target.

The department was actively involved in research projects and were planning to hold their 2nd research engagement day in June organised in collaboration with the research team. Leaders told us how projects were completed by various staff members including junior doctors, consultants, nurses, and the research team.

Competent staff

The service did not always sure staff completed specialist training for their role. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Managers did not always make sure staff completed any specialist training for their role. Staff raised concerns that it could be problematic to determine who out of the nursing staff was tracheostomy trained and there was not always someone available to do this; there was also a similar concern around male catheterisation.

Tracheostomy training had been part of the new starter programme at the hospital since 2022 and there were some staff that were signed off as tracheostomy trained from previous clinical areas. This equated to 48% of nursing staff that who had completed their training. Once this training was completed, a sign off would be required, which due to the infrequency of tracheostomy patients within the department, had required the staff to rotate to an area where there was an opportunity for sign off such as the intensive care or neurology wards. Leaders told us how practically this had been difficult to achieve and as a result alternative methods off sign off were being discussed trust wide. We told the trust it should ensure that staff are able to quickly identify which staff on their shift have specific key skills and competencies such as being trained in tracheostomy and male catheterisation.

Urgent and emergency services

At the time of the inspection non-invasive ventilation (NIV) was a physio service. When a patient was found to require NIV support, the physio on call was called to the department to carry this out for the patient for the duration of their stay where they were then nursed within resus area. There were guidelines in place for ward based non-invasive ventilation.

Leaders told us in order to capture the rest of the nursing staffing, the NIV training package was to be incorporated into the rapid sequence induction study day.

New nursing staff had a 6-week set programme to complete which included topics such as trauma and resuscitation.

The nursing lead undertook spot checks throughout shifts and provided ad hoc mini teaching sessions to support and improve practice.

New starters within the department were given theoretical training on the use and completion of paediatric early warning scores (PEWS). Pre-COVID-19 groups of staff completed additional training and went to the emergency departments within the trust to complete sign off on competencies relating to PEWS.

Due to COVID-19 and staffing constraints these visits and training had been paused but were being reintroduced with a plan for multiple staff groups to receive the training over the coming months. The plan was they would then complete the PEWS competency form.

A paediatric study day was due to be introduced to the new starters programme to increase educational compliance relating to PEWS.

There was a dedicated paediatric emergency department matron in place that that worked across site sharing learning and best practice with the emergency department team. They also attended band 7 meetings, additionally there was a band 7 lead for paediatrics within the department.

Leaders told us over the past 2 months, the speciality had recruited a dedicated paediatric clinical educator to develop the paediatric study day and aid training across all hospital sites.

At the time of the inspection there were no paediatric trained nurses in the hospital's emergency department. Leaders told us that a wider piece of work relating to progressing members of staff to become dual trained by a top up course was being explored. However, the trust had a paediatric liaison service who reviewed daily admissions of patients under 18 years old in relation to safeguarding.

There was no evidence of departmental team meetings for non-senior members of staff. We saw meeting minutes were available on request.

Managers gave all new staff a full induction tailored to their role before they started work. There were local inductions in place for all staff including nurses, students, and agency nurses.

Managers did not ensure staff had regular appraisals of their work. Appraisal rates were mostly low; data from March 2023 showed the only staff group to achieve 100% compliance was medical secretaries. The department recorded figures under different staff groups and labelled them as A&E. Compliance levels were low for emergency nurse practitioners (42%), A&E department (29%), A&E ward (39%) and A&E secretaries (50%). The improvement of appraisal rates was identified as an area of improvement following our last inspection.

Urgent and emergency services

Consultant leads used an appraisal template for medical staff which was in line with the General Medical Council requirements. Leaders told us their approach included using appraisal as a source of support, an opportunity to focus on wellbeing and for reflection.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Non-trainee medical appraisal rates were 65%. The chief medical officer's services team worked closely with the senior medical leads for revalidation and appraisal to support non-trainee medical staff with their appraisals. Leaders told us their completion rates were increasing and that they were working to achieve their pre-pandemic rate of 88%.

The clinical educators supported the learning and development needs of staff. The department had clinical educators in place. New nursing staff had a six-week set programme which included topics such as trauma and resuscitation The band 7 clinical educator kept a live spreadsheet with staff trajectories. Training and inductions were in line with the Royal College of Nursing ED level 1 and level 2 competency workbooks.

There was a clinical educator in place for mental health. The role of the educator was to work across the vulnerability team, looking at compliance with the Mental Health Act and educating staff around mental health and care.

Managers identified poor staff performance promptly, however policies in place to support this were out of date. The trust had various policies and procedures in place to utilise in cases of poor staff performance. Relevant policies and procedures included a disciplinary procedure (review date September 2022) and an employee relations policy (review date June 2022), these policies were overdue a review.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

All necessary staff including those of different teams, services and organisations were involved in assessing, planning, and delivering care and treatment.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were calls across the hospital system twice daily to discuss patients presenting with a mental health need. The calls involved other trusts and the local integrated care board.

We observed doctors, nurses and other staff working together for the benefit of the patients. These included the hospital safeguarding team, the Older Persons Assessment and Liaison team (OPAL) team, the alcohol liaison team and the psychiatric liaison team.

Staff referred patients for mental health assessments by the psychiatric liaison team when they needed them such as if they were suffering mental ill health.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. Prior to the COVID-19 pandemic the trust carried out manual audits of compliance with the seven-day services standards, the requirement to undertake these audits was suspended due to the pandemic. Leaders told us that they planned to restart the audit programme from Autumn 2023.

The hospital had a pharmacist available. A pharmacist led service (7am to 11pm) was based within the acute medical unit.

The hospital psychiatric liaison team were available 24 hours a day 7 days a week. However, often Approved Mental Health Act professionals were not available after 3pm.The alcohol liaison team, OPAL team and the vulnerabilities team were available in the daytime hours.

The hospital had 7day consultant cover for emergency admissions in line with national practice.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff signposted or referred patients to other services if required.

There were information boards available for patients, displaying information around sources of support including contact details of the Alcohol Care Team, Shelter, Mind, Refuge, Samaritans, Papyrus and Cruse.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, not all staff understood their responsibilities under the Mental Capacity Act.

Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There were varied levels of understanding around the Mental Capacity Act 2005 amongst hospital nursing staff, with some confusion between the Mental Health Act 1983 and the Mental Capacity Act 2005 evident.

There was provision in patient records to record the patient's mental capacity. There were forms in place for adults who lacked the capacity to consent to care and treatment. The forms included a tick box around the assessment of patient's best interests, and an assessment of the patient's capacity. There was also a section for staff to record involvement of the patient's family, power of attorney, or health professionals involved with the patient.

Not all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). The trust provided training for staff on capacity, consent and best interests, the total number of staff who had completed this was 79.

There was separate training around safeguarding, Mental Capacity Act and DoLS, 40 staff had completed this. The hospital did not provide the details of how many staff had not completed this.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff recorded patients' consent on their care records. There was patient agreement to investigation or treatment forms available staff to use if relevant.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. The hospital safeguarding team supported the staff with any referrals. There was a Mental Capacity and Best Interest policy in place. The policy was out of date as the review date was November 2022.

Urgent and emergency services

The Mental Capacity and Best Interest policy contained details around children under 16 who lacked capacity, Gillick Competency, and best interest decisions. The policy also signposted staff to other useful information such as the Mental Capacity Act 2005, codes of practice and the Nursing and Midwifery Council website.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff members displayed understanding and a non-judgmental attitude when discussing patients such as those with a mental health need.

When staff provided personal care to patients, we observed they closed the curtains. We observed 2 patients being triaged and saw staff acted in a caring manner towards patients.

Patients said staff treated them well and with kindness. Patients spoke positively about the staff that were caring for them. Patients felt that staff responded in a compassionate, timely and appropriate way when they were in pain or physical distress.

Patient comments on the care they received included staff being “nice and friendly”, nurses being “kind and helpful” and the staff being “brilliant” and “polite”. One patient who was in the department due to their mental health told us how the staff were ‘amazing’.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

We observed staff caring for patients on a 1 to 1 basis. When patients required some privacy and dignity, we saw staff sat outside and remained as discreet as possible. Patients felt that their privacy and dignity was respected. However, privacy and dignity and communication and regular updates were noted as a theme requiring improvement in the patient experience group report dated April 2023.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the impact that a person’s care, treatment, or condition had on patients’ wellbeing and on those close to them.

Urgent and emergency services

The hospital had a psychiatric liaison team in place for patients who needed support with their mental health needs.

Staff understood patients' personal, cultural, and religious needs. The trust had a chaplaincy team which included representatives from 6 of the major world faiths:

- Buddhism
- Christianity
- Hinduism
- Islam
- Judaism
- Sikhism

Within Christianity, the chaplaincy team also had Anglican, Free Church and Roman Catholic chaplains who offered the sacraments including bedside communion and the sacrament of the anointing of the sick. Eucharistic ministers could also bring communion on request. The chaplaincy team were happy to visit people whom belonged to another faith or to put them in contact with a member of their own faith or belief group. The trust provided staff with training around inclusion and diversity.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff helping a patient who had become distressed in an open environment and supporting them to have their needs met.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff communicated with people so that they understood their care, treatment, and condition.

People’s carers, advocates and representatives including family members were identified, welcomed, and treated as important partners in the delivery of their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

The feedback from the emergency department survey test was varied. The hospital participated in the friends and family test. Feedback from April 2022 to February 2023 was not yet published. We reviewed the data from 2020 in which 286 people participated. Results covered all University Hospital of Birmingham NHS Foundation Trust sites and showed the trust scored worse than most other trusts in relation to the question ‘after leaving A &E, was the care and support you expected available to you?’

The ED patient experience task and finish group was working to address these concerns.

Communication aids were not readily available or replenished for patients who did not communicate verbally or had sensory disabilities.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers tried to plan and organise services so they met the needs of the local population. Leaders told us that the needs of the local people were an important consideration when developing the service and making any changes.

Where people's needs and choices were not being met this was identified and used to inform how services were improved and developed. Proposed changes to any services were taken to the relevant meetings for each site.

At the time of the inspection ED leads were undertaking a piece of work to improve the experiences of patients within the emergency departments. The group working on this included patient representatives; staff involved were working closely with the trust's patient experience team to ensure the voice of patients and carers was heard.

The department had the ability to competently stream appropriate patients to a GP service. The GP services operated 7 days per week with variable appointments as per the site requirement. Leaders told us how this had a positive impact on patient experience and time to be seen and they had received lots of positive feedback as a result.

The GP service could offer 66 slots per day. Additionally, the service was able to offer and refer patients into an offsite GP service located within the Birmingham and Solihull area.

The hospital ED policy was that they did not treat children under 16 years old, except in life threatening situations. This was communicated to the public on the hospital's internet site. However, records showed that between May 2022 and April 2023, 2266 children had been seen, triaged, treated, and discharged home for further follow up in clinic or by their GP; Out of these, 164 children were transferred out. This indicated that the message was not always reaching the public. There was a policy in place for the transfer of children aged 0-16 presenting to the ED.

The hospital had an ambulance decision area (ADA) where patients were taken to avoid them being held on ambulances for long periods of time.

The ADA operated within an agreed standard operating procedure that was produced in collaboration with the local ambulance trust. Whilst patients were in the ADA local ambulance assigned personnel were responsible for observations at a minimum of hourly.

Alongside hourly observations, ambulance personnel were deemed competent to complete other skills such as cannulation, venepuncture, and urinalysis.

Local ambulance staff assisted to ensure patients' needs were met such as accessing toilet facilities, skin and falls assessments and nutrition and hydration.

Urgent and emergency services

Ambulance staff were expected to adhere to trust guidelines. Audits were completed around patient assessment and care provided. Actions from all sites included reiterating that skin checks should be documented within 6 hours and to ensuring that line managers supported staff completing assessments.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems There was a psychiatric team available 24 hours a day, 7 days a week. However, approved Mental Health Act professionals were not available after 3pm. This meant patients requiring a Mental Health Act professional after 3pm may not always be able to access them in a timely manner.

There was somewhere appropriate for patients to wait while admission to a psychiatric unit or other action was arranged.

There was a relatives' room where people could go, for example if they received bad news. The matron told us they were planning on creating a quiet room for distressed patients who may need it; for example, patients that may find busy environments distressing.

There was adequate seating and space in the reception and waiting areas for patients and people accompanying them.

The facilities and premises were appropriate for the services being delivered, however, in majors due to the previous COVID-19 pandemic, individual cubicles had been fitted with doors which leaders told us meant hospital beds could not fit into the cubicles if needed. However, this meant patients were at increased risk of pressure damage due to remaining on hospital trolleys when in the department for a long time.

Meeting people's individual needs

The service coordinated care with other services and providers. However, they were not compliant with the Accessible Information Standard. Information in other languages was not available in the department.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had a vulnerability team whose aim was to work collaboratively to meet the needs of individuals. The vulnerability team provided additional support to staff in relation to patients with learning disabilities, autism, mental health, and sensory impairments.

The vulnerability team helped to set standards and looked at whether patients had their all about me passports. The team was staffed by learning disability, general and dementia specialist nurses. We did not see any "this is me" or "patient passports" in use at the time of the inspection and staff were not able to tell us about any special measures that were in place for patients with dementia or a learning disability.

The vulnerability team visited the emergency department on a daily bass and held a list of patients who may have needed their support.

The hospital had volunteers from the hospital chaplaincy team who visited patients for a chat. They also told us they could make the patient a drink if it was safe to do so.

The service did not have information leaflets available in languages spoken by the patients and local community. Staff we spoke with were not aware of any leaflets for patients in other languages at the time of the inspection.

We noted that the safeguarding and vulnerabilities team had corresponded with staff around accessibility information standards training.

The service was not compliant with the Accessible Information Standard at the time of our inspection. The Accessible Information Standard says that people who have a disability or sensory loss should be given information in a way they can access and understand. This has been a legal requirement for providers of health and social care since 2016.

There was an accessible information standard action plan in place. The action plan included training to increase staff awareness of patients with a disability or sensory loss, and providing information to all patients in a way they can understand so they can give consent to care and treatment. Actions still identified as outstanding included revising letters for appointments, ensuring the Accessible Information Standard procedure is agreed locally and that standard operating procedures were in place, standardising processes of how the trust asked about communication needs standardising the information require from referring agencies and creating an accessible information standard quality and performance dashboard.

Staff did not have access to communication aids to help patients become partners in their care and treatment. We looked in a communication box, which was held on the ward, however, at the time of the inspection this was found to be empty apart from a hearing amplifier. Staff told us the boxes should have contained aids such as a communication book, magnifying glass, a ruler to aid reading for patients with dyslexia, a British Sign Language finger spelling sheet and a spectacle repair kit.

Managers made sure staff, and patients, loved ones and carers were aware of services such as interpreters when needed. There was a telephone interpretation service staff could use if patients had any translation needs. This service was advertised throughout the department.

Access and flow

People could access the service when they needed it and received the right care promptly. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards. The trust was working to reduce waiting times in the department.

Managers monitored waiting times to ensure patients could access emergency services when needed and received treatment within agreed timeframes and national targets, however, they did not always achieve this. During the inspection process we saw patients were being seen within the 15-minute initial triage target.

Triage times were monitored using the trust's electronic systems. The process was that the triage nurses would allocate a triage category following the Manchester Triage guidelines. This allowed the nurse in charge, consultant in charge and anyone else to be able to see who was next to be seen by the clinicians according to a priority score. Recording such details of the patients waiting on arrival provided assurance that the sickest patients had been identified to ensure they were seen first.

Leaders told us overcrowding remained a challenge. At the time of our inspection there were enough chairs for the patients and relatives waiting in the department. A local escalation policy had been developed in agreement with the divisional team, with the trust wide response. The guide included a guide of when to escalate and who to ask for help within the trust.

Urgent and emergency services

To improve triage times, the trust had implemented changes to ensure time critical and self-presenting patients were picked up promptly. Changes included the implementation of a priority triage card kept by the triage nurse and navigator, reallocation of emergency care technician to work directly with the triage nurse to complete urgent ECG's or bloods for example chest pain or neutropenic sepsis patients. The navigator directed the patient to the appropriate place for example to minor injuries, to see a GP or to be triaged.

The hospital had several hospital ambulance liaison officers (HALO's) based in the emergency department at the front door. The role of the HALO was to work with ambulance crew and hospital staff to help reduce the time an ambulance waits at the department.

The percentage of patients in the department over 6 hours was 44% (February 2023), 45% (March 2023) and 38% (April 2023); this showed a fluctuating picture.

The percentage of admissions achieving the 4 hour wait target was 50% (February 2023), 51% (March 2023) and 59 % (April 2023), showing some improvement.

The percentage of admissions waiting from 4 to12 hours from decision to admit were 35% (February 2023), 34% (March 2023) and 33% (April 2023).

The trust had completed a high-level review of speciality patients seen in the trust's emergency departments who spent between 4 hours and 12 hours in the department before being discharged home by the speciality team.

The review included all referred patients for each speciality that attended the hospital during December 2022 and January 2023. Results showed that the average time spent in department was 419 minutes for ear nose and throat, 366 minutes (patients with hand complaints), 399 minutes (trauma patients), 422 minutes (maxillofacial patients), 493 minutes (neurosurgical patients) and 433 minutes (surgical and urology patients).

The hospital monitored ambulance handover times and worked collaboratively with the local ambulance trust to try to reduce them. From the 27 March to 26 April 2023, 3291 patients arrived by ambulance. Out of these, handover delays of over 60 minutes happened on 156 occasions and over 30 mins on 634 occasions. Handover delays have a detrimental impact on patient care on the frontline and increases the risk of deterioration in patients at home in need of urgent care.

There was an externally funded ambulance decision area within the department that was staffed 24 hours a day with paramedics and ambulance care assistants. The area was overseen by the trust and had the capacity for 12 patients. Doctors and nurses from the department visited the areas as required. The trust was the first trust in the country to provide this service and approximately 40000 patients had been seen across sites between September 2022 and December 2022.

The ADA patient throughput audit throughout November 2022 to February 2023 showed the overall average time spent in ADA was 8 hours a day.

There was a navigator nurse based on the front door 24 hours a day. The navigator directed the patient to the appropriate place for example to minor injuries, to see a GP or to be triaged.

We reviewed the ED improvement programme which identified various workstreams and pathways to improve access and flow in the department. This included a PUSH model, however, feedback from staff was that this was not working as well as it could.

A 'push model' of moving patients out of the Emergency Department (ED) into inpatient wards was used to support the management of inpatient flow. The model involved a set minimum number of transfers each hour out of the ED to identified areas in the trust regardless of bed availability, with inpatient wards utilising the discharge lounge and other early discharge methods (for example, discharge pharmacy) to ensure that any additional patients are boarded on the ward for the least time possible.

The emergency department mental health group report dated April 2023 showed that the 5 longest patient stays for mental health patients between 2 January 2023 and 15 January 2023 were between 61 and 111 hours. All delays were escalated in the daily system wide mental health call following the escalation policy. The number of patients leaving the service before being seen for treatments was low. Data showed that the percentage of patients leaving before being seen was 6% (February and March 2023) and 4% in April 2023, showing some improvement.

Staff planned patients' discharges carefully, particularly for those with complex mental health and social care needs. Managers and staff started planning each patient's discharge as early as possible. Local leaders told us they did not have many incidents regarding discharge.

The psychiatric liaison team were based some distance away in the hospital which ED staff reported contributed to delays. Patients who were deemed to be medically fit could go to a local hospital for patients with mental health needs.

The trust Older Person's Assessment and Liaison team worked with the emergency department to facilitate more timely discharges included access to equipment, care packages and through liaison with care establishments.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns. We reviewed 2 complaints and their responses and found the trust had investigated the concerns, apologised, when necessary, provided details of who to contact if they had any further queries and that they provided the details of the Parliamentary and Health service Ombudsman if the complainants were not happy with how the complaint had been dealt with. We saw complaints were discussed within emergency departments' operational meetings.

Managers shared feedback from complaints with staff and learning was used to improve the service. Themes and trends were regularly monitored in the department. As part of the wider divisional governance structure the emergency department had a speciality level meeting where complaint's themes and trends were reviewed. They also had the division 3 patient experience group and preventing harm meetings where themes and trends from complaints and patient feedback were reviewed. These meetings reported into the divisional and quality and safety meetings, which reported into the divisional board.

Urgent and emergency services

Complaint themes were reviewed for each site and changes had been implemented in response to themes. For example, concerns were raised about the length of time to get through on the phone to nursing staff. As a result, a trial was being undertaken where a communication team had been set up to facilitate the timeliness of calls into the department and to help answer calls more quickly.

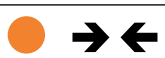
We reviewed the patient experience group report dated April 2023 and found main themes included:

- Considerable waiting times to be seen.
- Access to phone chargers.
- Broken vending machines.
- Lack of food and water.
- Pain relief whilst waiting to be seen.
- Communication and irregular updates.
- Privacy and dignity.

Positive feedback reported included:

- Staff attitude.
- Communication regarding treatment plans.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, staff opinion varied around their local leaders being visible and approachable.

Staff opinion varied around the supportiveness, approachability, and visibility of their local leaders. Some staff felt that they were well supported, and found local leaders approachable, whilst others spoke of limited visibility and support.

Leaders had the skills, knowledge, experience, and integrity they needed. The leadership team was made up of a triumvirate, where 3 leads oversaw the department. This was supported by divisional leadership. The divisional leadership included a medical director, a deputy medical director, a director of operations, and a deputy director of nursing.

The matron was recent in post. Therefore, at the time of the inspection they were still in the process of learning and familiarising themselves with the department and had set priorities such as restructuring the department and supporting current band 7 staff to take on additional responsibilities and ownership.

The divisional leadership team told us support for new matrons included robust handovers, cross site matron relationships, a matron group, a recently appointed quality and safety matron and cross site peer support. There were band 7 nurses in post who supported the matron with the day to day running of the department.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision in place which was to build healthier lives. The trust aimed to be a key partner as part of an integrated health system with 9 supporting strategic aims.

At the time of the launch leaders told us the strategy was disseminated to all staff through several meetings, including the trust's monthly all staff team brief.

Details of the strategy were also available on the trust website and new staff were introduced to the strategy and its underpinning values as part of the induction process.

The trust had a strategy implementation plan to deliver its strategy which was available to staff on the trust's internal systems.

There was a set of values in place which involved being kind, connected and bold, and staff knew where to look to find information on it.

Culture

Staff opinion varied about being supported and valued. Staff survey results showed that staff did not always feel concerns would be addressed. However, staff were focused on the needs of patients receiving care.

There were some arrangements in place to keep staff and others safe and protected from violence. There was 24-hour security on the front door and the department was equipped with closed circuit television. There was a Mental Health hotline for NHS staff with a text 24-hour service. However, there were concerns regarding the mental health assessment room not being locked and leading into the reception area which had not been addressed prior to the inspection.

The staff survey 2023 addressed diversity and equality in the workplace. Results showed that 61% of staff felt the organisation respected individual differences such as culture, backgrounds, and ideas, 50% felt the organisation acted fairly around career progression, and 86% of staff had not experienced discrimination from a manager or colleagues.

The staff survey had addressed how confident staff were to raise concerns in the department. Results showed staff felt confident to share concerns about unsafe clinical practice. However, results also showed staff did not feel confident the organisation would address concerns about unsafe clinical practice or other concerns.

Leaders told us following the staff survey results being published, the results were discussed at the cross-site ED directorate meeting on the 19 April 2023. The teams were devising an action plan and a follow up meeting has been arranged to finalise the action plan. In addition to this an ED staff engagement forum was being set up. The forum was being set up with a terms of reference.

There was a Freedom to Speak up Guardian in place, however, not all staff were aware of them and their function.

Support for long term sickness cases and complex cases were supported by human resource colleagues and occupational health. Return to work interviews were undertaken to see if any adjustments were needed.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations.

Staff did not consistently follow policies and procedures in place, and this was not always identified. We found significant gaps in the checks around resuscitation trolleys including in minors, majors, and resuscitation areas. This had been raised on a previous inspection of the department and remained an issue that had not been rectified by the trust's governance processes.

Medicines were not managed safely which was due to the disorganised storage arrangements in place. The trust was issued with a requirement notice following the last inspection which required the trust to ensure they consistently followed systems and processes when prescribing, administering, recording and storage of medicines. Following the inspection, the trust acted promptly to rectify the above issues in relation to medicines storage and resuscitation trolley checks and provided evidence of this.

There was a newly implemented mandatory training action plan in place, however, none of the actions had yet been completed or achieved and there was no colour coding to show the most important actions. Additionally, there was no date to show when the action plan had been completed or when it would be reviewed. Therefore, we were not assured that there were sufficient measures in place to improve mandatory training compliance. On the previous inspection we told the trust it should ensure all staff were up to date with their mandatory training.

Appraisal rates remained low. On our previous inspection we told the trust it should ensure appraisal rates were improved in line with action plans.

We observed staff not adhering to infection prevention control procedures for example wearing watches and long sleeves. However, we did hear of this being challenged by leaders on one occasion. This meant staff were not always doing all they should to reduce transmission of pathogens that may occur due to contact of the patient with any contaminated clothing.

We requested meeting minutes from all levels of seniority and found the trust held regular oversight meetings. In line with the trust governance model the department also held monthly speciality meetings with terms of reference in place. The emergency department triumvirate then reported into the divisional quality and safety meetings. Additionally, each site held triumvirate and band 7 meetings. We were not provided with any meeting minutes for other non-senior staff in the department.

Quality and safety meetings were held and included topics such as infection prevention control, the risk register, and clinical guidelines.

All service level agreements provided by 3rd parties were recorded within the trust financial accounts and governed through standing financial instructions for the financial aspects. The trust also held meetings with service providers to regularly review operational performance and clinical quality. For the ambulance decision area and hospital ambulance liaison officer (HALO) service level agreement the trust held daily meetings with the head of patient flow in conjunction with a dedicated matron for oversaw the services.

As well as staff exit interviews; 'stay interviews' had also been launched across the speciality. Leaders had collected data on the reasons people were leaving the department which included nursing concerns around overcrowding and increased length of stays.

The trust had a matron from emergency care on the trust pressure ulcer steering group who reviewed all divisional pressure ulcers and compiled a monthly report.

Leaders told us a particular focus was on the emergency department and patients developing pressure ulcers from an increased length of stay within the department. Leaders also told us how delays in transfer and reduction in flow from the department was being addressed and how addressing such issues with flow would reduce the time spent in ED and therefore the risk of patients developing pressure areas.

Management of risk, issues, and performance.

Leaders and teams used systems to manage performance. Systems to manage risk, issues and performance were not always effective. However, leaders knew the significant risks and tried to reduce their impact.

There was an emergency medicine risk register in place which identified risks within the department as well as listing the controls that were in place. Risks included staffing, skill mix, patient flow, availability of beds for patients living with mental health condition, offloading from ambulances, safeguarding and medicines.

There was a programme of clinical and internal audit to monitor quality and operational processes, however, they had not picked up issues that were a risk such as those around the storage of medicines or the resus trolley checks.

Leaders named the top risks at the hospital as ambulance off loads, priorities to see patients, staffing and the overcrowding in the emergency department with mental health patients being at risk of long stays.

There were processes in place for when there were shortfalls with nursing staff. For example, nursing escalation actions were undertaken to ensure divisional oversight of the staffing position. Local actions were reviewed by a band 7 and matron. If the risk was not able to be mitigated, then escalation was completed to the deputy director of nursing and when necessary, the site integrity lead.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff were able to access the trust intranet site to access any policies and procedures needed to carry out their roles effectively. However, these were not always up to date. Information governance training was including in the trust mandatory training schedule.

There was a television in the waiting area, however, at the time of the inspection it did not display useful information such as length of waits.

The department collected reliable data and analysed it. Such information was used in audit processes and quality improvement projects.

Urgent and emergency services

Engagement

Leaders and staff actively and openly engaged with patients and staff.

Senior leaders told us they completed walk arounds of the department on a regular basis. Local leaders communicated with staff, for example we saw student boards with information for student nurses as well as an education board. We also saw updates on notice boards for leadership courses.

Staff were given the opportunity to participate in staff surveys. Results showed the hospital scored 18 positive scores which were the same or better than the trust average, 7 positive scores up to 3% below the trust average, and 71 scored 4% or more below the trust benchmark. Forty-three percent of staff reported they would recommend the organisation as a place to work.

Following the most recent staff survey results were discussed cross sites in April 2023. Leaders told us they were currently working on an action plan in response to the survey and a follow up meeting had been arranged to finalise the plan in May 2023.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The division reported on quality and safety matters, including themes and trends to the joint clinical quality and assurance group, which was co-chaired by the chief nurse and chief medical officer.

The department was actively involved in research projects and were planning to hold their 2nd research engagement day in June 2023 organised in collaboration with the research team. Leaders told us how projects were completed by various staff members including junior doctors, consultants, nurses, and the research team.

As a result of trends from complaint themes, a working group had been implemented to improve patient experience across the emergency departments. This groups aim was to focus on key themes such as food and drink provision, communication, and information sharing. Following the initial meeting, walk rounds have been scheduled in all the departments with the local teams.

Leaders told us how they had participated in a chronic obstructive pulmonary disease management audit which led to a quality improvement project and educational package to improve quality of care.

We saw a patient safety notice had been completed around the safe use of oxygen cylinders following a National Patient Safety Alert. Additionally, an assurance process for patient safety alerts was established in July 2020 and was presented to quality meetings and the trust board quarterly. The assessment included a review of audits and documentation to demonstrate processes were in place as well as a review of the incidents. Once assurance /audits were established these were monitored and any non-reassuring results were followed up by monthly reporting and continuous monitoring.

Staff completed a spot check audit for pain management. As a result of the audit additional focus had been given to pain assessment in training and on courses provided.

Urgent and emergency services

As a result of patient survey results and complaint themes, a working group was established in March 2023 to focus on improving the patient experience at all 3 emergency departments across University Hospitals Birmingham NHS Foundation Trust. The membership of this group consisted of a range of staff groups from across the trust, along with patient representatives, and was chaired by the head of patient experience.

The group was responsible for a number of improvement initiatives aimed at improving patient experience within the emergency departments such as the environment, facilities available to patients such as access to mobile phone chargers, water, and entertainment, along with full review of cleaning schedules. Following the initial meeting, walk rounds had been scheduled in all the departments with the local teams.

The most recent patient experience action plan was based on the 2018 national survey results and went to the patient experience group in November 2019. This was paused after a few months due to the COVID-19 pandemic. The 2020 survey results were then published which showed more positive results therefore no specific action plan was produced. An emergency department taskforce was then put together to improve the emergency department and to focus on the issues that the patient experience team were seeing.

To improve triage times the trust had implemented changes to ensure time critical and self-presenting patients were seen promptly. Changes included the implementation of a priority triage card kept by the triage nurse and navigator and reallocation of emergency care technicians to work directly with the triage nurse to complete urgent ECG's or blood tests.

Cancer services

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

Not all staff had up to date mandatory training.

Not all staff kept up-to-date with their mandatory training. All staff had completed a corporate and local induction. Between 98% and 100% of staff had completed specific clinical modules to support their specialist role. However, some modules were below the trust's target of 90% compliance. These included, fire safety, health, safety and welfare, conflict resolution and information governance, where compliance was only 50% on one of the wards.

Training modules included inclusion and diversity, and conflict resolution, as well as resuscitation modules and clinical modules aimed at keeping patients safe.

The mandatory training did not always meet the needs of patients and staff. Information provided by the service highlighted that not all clinical staff completed training on recognising and responding to patients with learning disabilities and autism. This was not in line with statutory requirements and meant that the service could not be assured staff recognised or knew how to care effectively with people living with such conditions.

Safeguarding

Not all staff had training on how to recognise and report abuse and they knew how to apply it.

Not all staff were up to date with training specific for their role on how to recognise and report abuse. Qualified nurses told us they were trained to safeguarding vulnerable adults' level 3 and above and support staff were trained to level 2. However, mandatory training compliance figures ranged between 55% and 100% across the service. Specifically, 3 wards ranged between 55% and 86% compliance for safeguarding level 2. This meant that not all ward staff were up to date with safeguarding training and the trust's target for compliance was not being met.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Referrals were usually made by qualified nurses. Healthcare assistants and other support staff would inform the nurse in charge. All staff were aware of the processes and where to find referral information.

Staff followed safe procedures for children visiting the ward. Most wards had restricted visiting to protect vulnerable patients, including on the young person's unit.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There was an enhanced level of cleaning on the haematology and oncology wards due to the clinical vulnerability of the patients being treated there. Strict hygiene and cleanliness measures were in place. All staff and visitors were screened before entering the ward. Every visitor was required to conduct a lateral flow test to check whether they had COVID-19. Anyone who tested positive was not allowed to visit the ward.

Managers carried out cleanliness audits to check the high level of hygiene was maintained. We reviewed their most recent audits across the service and found these were between 96% and 100% compliant across the service.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed all staff follow the 'bare below the elbow' policy and maintain good handwashing practices. There was an adequate supply of hand gel at patient bedsides and washing facilities in each bay and room. There was suitable signage and instructions visible where barrier nursing or extra protection measures were in place for patients to prevent the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff kept cleaning logs for all areas to show compliance with cleaning protocols and to reassure staff and patients about the safety of the environment. Managers checked cleaning compliance.

Environment and equipment

Staff did not respond promptly to call bells or device alarms. There were not enough MRI scanners to meet the needs of patients. However, the design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

Patients could reach call bells, however, patients told us that staff rarely responded quickly when called due to staff shortages on the haematology and oncology wards. This meant that patients often waited longer for staff to attend to their needs. Patients said that alarms on their medical devices often went unattended because staff were too busy with very sick patients elsewhere and sometimes would turn off the device alarm and return much later to attend to it.

Staff carried out daily safety checks of specialist equipment. Managers ensured that equipment had been tested and serviced regularly.

The service did not always have enough suitable equipment to help them to safely care for patients. Senior leaders from the radiology department told us that there were not enough magnetic resonance imaging (MRI) scanners to meet the growing demand for diagnostic and review scans. One existing scanner was awaiting replacement and others were awaiting repair due to breakdowns. Three out of 7 scanners were not available to use at the time of our inspection. The trust had commissioned 2 portable scanners for use in the community and a further 2 at Birmingham Heartlands Hospital. They had also commissioned the services of an independent provider to carry out scans to help ease the backlog of referrals.

However, there was enough suitable equipment to safely care for patients on wards.

Staff disposed of clinical waste safely. This included cytotoxic medicines.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient; however this was not always within a timely way. Staff took prompt action to identify, treat and track patients with sepsis. However, doctors could not always communicate risk issues with nurses in a timely way due to nurse staff shortages.

Cancer services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff recorded regular physiological observations using the National Early Warning Score (NEWS2) system electronically. Staff used an electronic handheld device to record scores which automatically calculated the total score. This enabled senior clinical staff to receive an automatic alert when a score triggered a concern. The alert required medical staff to confirm if there was a sepsis risk and initiate the appropriate treatment. The system provided a live report for staff to identify patients who had a diagnosis of sepsis and track any who had not received antibiotics within 1 hour of diagnosis. Senior staff had oversight of this. Ward staff told us that medical staff responded quickly to NEWS2 triggers due to the vulnerability of the patients being cared for. We reviewed a snapshot report generated by the trust from 1 November 2022 to 30 April 2023 which showed that 100% of patients acknowledged as having a diagnosis of sepsis had received antibiotics within 1 hour. The data provided by the Trust included patients who may have started antibiotics, based on initial clinical diagnosis or raised NEWS in the emergency department.

Staff did not always complete risk assessments for each patient on admission, or review these in line with national best practice in a timely way. Staff completed most patient risk assessments on the electronic system which all staff could access via the trust's computers and handheld devices. There were still some patient assessments being completed on paper and these were kept in a folder at the nurse's station. Staff completed patient assessments comprehensively. Where specific risks were identified, nursing staff requested input from therapy staff, such as physiotherapists.

The service monitored completion of risk assessments and reported some in their clinical dashboard. Audit results of observational and pain assessments completed within 6 hours of admission varied between 78% and 98% against a target of 95%. Observational and pain assessments completed within 12 hours of admission showed a compliance of 99% against a target of 99%.

We saw that during the period November 2022 to April 2023, compliance with completing nutritional assessments varied between 75% and 95% against a target of 95%.

Staff knew about and dealt with any specific patient risk issues. such as sepsis, falls, nutritional needs, pressure ulcers and risks associated with long term use of cannulas. These were all recorded and checked daily or weekly. However, some assessments were not always completed in a timely way.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Where necessary, specialist agency staff were employed to provide one-to-one care and observations of very vulnerable patients with mental health issues, dementia and learning disabilities.

Staff shared key information to keep patients safe when handing over their care to others. Information was shared between all health professionals involved in patients' care through the electronic system. Ward rounds were conducted regularly and involved a multidisciplinary team (MDT) where possible, including physiotherapists, occupational therapists, the pharmacy team, nurses and treating physicians. However, on some wards, the ward round did not include nursing staff due to the shortage of qualified nurses available. Where MDT ward rounds were not possible, consultant teams completed the rounds with medical staff and recorded their decisions in the patient records electronically. The nursing staff were then able to access the records when needed and contact the physician for further advice if needed. Staff told us that where a member of the medical team needed clinical tests to be arranged urgently for patients during a ward round, they would inform the nursing staff immediately. Consultants told us that communicating with nursing staff was sometimes challenging due to staffing shortages.

Shift changes and handovers included all necessary key information to keep patients safe. Handovers occurred at the start of each shift on all wards.

Cancer services

Staffing

Nurse staffing

The service did not have enough staff. However, nurses mostly had the right qualifications, skills, training and experience to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff to keep patients safe at all times. Data provided by the trust showed there were 1196 unfilled shifts across the service between January and April 2023.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, they were rarely able to fulfil the staffing requirements adequately due to shortages of qualified nurses and healthcare assistants.

The number of nurses and healthcare assistants did not match the planned numbers. At the time of our inspection, data from the trust showed wards had a qualified nurse vacancy rate of between 11% and 40%. However, managers and staff told us that where there should have been 7 qualified nurses on duty during the day, there were usually only 3 or 4. There were also staffing gaps at night. The service held a meeting twice daily to discuss patient needs and staffing. They were able to adjust staffing levels each day across the whole service to meet the needs of patients as much as possible, but staffing levels still did not meet those planned. Staff were redeployed between wards, the outpatient day care service and other areas within the speciality to ensure each ward and area had qualified nurse expertise. However, even with redeployment, staffing levels were not adequate. Redeployment also meant that nurses who were specially trained to administer chemotherapy medicines were sometimes required to provide this service over multiple wards and day services when there were insufficient specially trained nurses on duty. This ensured that all patients receiving chemotherapy had this administered by an appropriate clinician with the right skills and expertise. However, this provided a challenge to patients receiving timely care. Staff told us there was a shortage of specially trained nurses who were skilled to administer chemotherapy medicines, but that more nurses were being scheduled for the 12-month training course.

In order to mitigate the nursing shortage, the service used a mixed speciality approach to provide cover for specific aspects of care on the relevant wards. For example, the service employed dedicated line technicians who were able to insert cannulas for patients and also provide a cannula care checking and assessment service which was highly valued by staff.

The service also used dedicated pharmacy technicians to manage discharge medicines and help prepare chemotherapy medicines among other activities. This freed up nursing staff to provide other priority care.

Ward sisters and staff told us that healthcare assistant gaps were sometimes filled by student nurses who provided general care to patients and assisted nurses. Student nurses told us this was a frequent occurrence which sometimes impacted on their learning, but that qualified staff generally went out of their way to ensure student nurses received sufficient experience and education to support their learning.

Medical staff said that the shortage of nurses often meant they were unable to find a nurse when they needed one, and that good communication between medical staff and nurses was sometimes challenging.

Managers limited their use of agency staff and requested bank staff who were familiar with the service. They offered an enhanced rate of pay to staff working on the bank as an incentive to work extra shifts. Rotas provided by the trust showed that bank staff were used on a daily basis to fill nursing rota gaps.

In the radiotherapy service, bank staff were used to fill gaps. Information provided by the trust showed that band 5 radiotherapy staff provided between 40 and 63 hours per month as bank shifts. The service had recently recruited 2 groups of international staff from abroad into the radiotherapy service and had provided comprehensive pastoral and financial support to help them settle into their new environment. This was to help reduce the stress sometimes experienced when moving to a new role in a new country, and to enable them to focus on their induction programme.

Senior radiographers (band 6, 7, and 8) had provided between 274 and 385 bank hours each month over the last 3 months to fill the gaps in senior radiotherapy roles.

Managers and staff reported staffing shortfalls as incidents through the trust's incident reporting system. There were 117 incident reports made due to staffing issues over the last 6 months.

We reviewed the most recent data provided by the trust to see whether staffing shortfalls had impacted on patient experience. We found that, in the last 12 months across all the cancer services the Friends and Family Test (FFT) had achieved an overall score of 98% of patients who would recommend the service to their family or friends. Wards 624 and 625 had not submitted FFT data and had therefore not been included in overall score. The trust encouraged patients to give feedback about their experience and this was reported on the service's performance dashboard. We saw that there had been a total of 85 compliments, 4 complaints and 27 concerns recorded by patients across the service.

The service had high vacancy rates. There were around 23 vacant positions across the service in total which equated to around 17%. Leaders and staff told us that the merger of cancer services from other local hospitals and the commissioning of one ward to the cancer service, which was previously a renal ward, meant that many staff resigned due to the changeover. Staff turnover and vacancies were still high at the time of our inspection on this ward.

Over the last 6 months the monthly sickness rate for nursing staff varied between 1% and 18% across the haematology and oncology wards.

The sickness rates for clinical radiotherapy staff ranged between 0% and 15% over the last 6 month period.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment in most areas. There was a shortage of radiotherapy staff in the radiotherapy department. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. There were enough consultants and other specialist staff, however, there was a shortage of radiotherapy staff due to sickness absence, and other absences. The trust had conducted recruitment drives and had recently recruited 2 groups of internationally educated radiotherapy staff. Leaders and managers anticipated that the new staff would make a positive impact on staffing capacity later in the year.

However, senior radiotherapy staff told us that the shortage of experienced radiotherapy staff had contributed to delays to patients receiving MRI scans over the last 4 to 5 months which had led to delayed diagnoses, treatments and patient reviews. Staff gave a recent example of a patient who required an urgent scan and waited 48 hours for a scan to become

available. Leaders told us that delays had been compounded by a recent surge of primary care referrals for MRI scans, as well as scanner equipment breakdowns. They had sourced mobile scanning units in the community and had commissioned an independent health provider to deliver some of the services for their NHS patients in an effort to catch up with the backlog.

Managers could not always access locums when they needed additional medical staff. We reviewed information provided by the trust which showed that out of 41 shifts put out for locum cover between September and December 2022, only 3 shifts had been filled by a locum. Most shifts were filled by staff working overtime.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on shift including evenings and weekends. There were always at least 1 consultant for haematology, transplant, haematology laboratory, and 2 consultants for oncology available 24/7 including bank holidays and weekends. In addition, there was a consultant available via telephone for each of the specialities. Staff told us they were always able to access a consultant for advice when needed.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Records were mostly electronic notes which medical, nursing and other health professionals could access easily on the computer system and other handheld devices. Some risk assessments were handwritten and stored in patient folders at the nurses' station. Staff told us they were in the process of migrating all patient assessments to the electronic system.

We looked at 10 sets of electronic patient records and 10 sets of written patient records, including risk assessments, and found these to be comprehensive and up to date. We noted that electronic patient records were updated by attending staff throughout each shift.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff used passwords to access electronic records and all written records were stored in a locked cabinet.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 5 prescription charts. These were legible and fully completed. Staff administered medicines safely by checking patients' identification and allergies and recording administration on the trust's electronic prescribing and medicines administration system. The ward managers ensured all medicines were administered appropriately during their daily ward round.

Pharmacy staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines when needed. Nursing staff usually provided medicines information when a patient was discharged. There were pharmacy technicians based on the wards to assist with discharge medicines.

Cancer services

Staff stored and managed medicines and prescribing documents in line with the provider's policy and followed current national practice to check patients had the correct medicines at the right times.

Staff learned from safety alerts and incidents to improve practice. The ward sister shared these with staff by email and discussed them at team meetings when these took place. This included learning from incidents where the wrong blood products had been administered. Additional training had been put in place to ensure staff were able to follow the trust's policy on safe administration.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and mostly reported incidents and near misses but did not always learn from them. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew how to report incidents and understood their responsibilities to raise concerns. Qualified staff reported incidents and near misses in line with trust policy. Junior staff had access to the reporting system but generally reported concerns to the nurse in charge and were informed of the outcome of these. However, we were informed by staff in one area that some incidents were not reported due to a blame culture in that area.

The main incident themes were pressure ulcers, falls, staffing, and medical records.

Staff raised concerns and reported incidents and near misses in line with trust policy. These were investigated and staff received feedback if they had been involved.

The haematology service had 6 never events within the service between 2019 and 2021, all of which were around the transfusion of incorrect blood products. Managers made some changes to their processes as a result of their investigations into these. However, the trust identified lessons learnt had not been shared widely enough or embedded into everyday practice. For example, there was a further never event reported in November 2021 where errors were identified regarding the processes used by laboratory staff and ward nurses in the preparation, checking and administration of a blood product to a patient. Leaders conducted an investigation and implemented an action plan to prevent the same thing happening again. All the nursing staff we spoke with were fully aware of the recent never event and the actions that had been taken at ward level. Appropriate staff had received additional training in the checking and administration of a certain type of blood product. However, it was too soon for CQC to assess whether the actions taken by the trust were sufficient to prevent this from happening again, given the number of times this type of event had been repeated.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. This included never events.

Staff met infrequently to discuss feedback and look at improvements to patient care. Managers were not able to hold regular and inclusive team meetings due to staffing shortages. However, where serious incidents had occurred, staff had received communication about the incidents and attended training to help prevent the same errors occurring again.

Is the service well-led?

Requires Improvement 

Cancer services

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood most priorities and issues the service faced but did not always manage these well. They were visible in the service but not always approachable for staff.

The cancer service comprised oncology, radiotherapy and clinical haematology specialities which were part of division 5 within the trust and also spanned other divisions.

Cancer services were led by a medical director for cancer services, a radiology service lead, a haematology lead and a clinical oncology lead. They were supported by clinical and operational leads across the divisions that provided services for cancer care.

Local leadership was provided by matrons and ward managers. Staff on some wards and areas were positive about their local leadership team and said they were visible and very supportive. However, some staff were unhappy with local and senior leadership. Staff on one ward told us they did not feel listened to or supported by local leaders and senior leaders due to several issues between staff not being resolved. Nursing staff from all levels on some wards reported increasing stress levels and a challenging work environment. Many staff were unhappy that they were unable to provide the level of care they expected for patients.

Matrons were based on wards and were accessible. They held daily briefings with ward managers to plan staffing, support across the service and assist with delivery of care when needed. Matrons attended monthly meetings with the Director of Nursing to review performance and risk. There were regular meetings for senior nurses according to role. There were opportunities for band 6/7 nurses to meet the matron and also band 5 nurses. Although staff said team meetings were not always consistent due to staff shortages, we saw that team meetings had taken place in April 2023 for most wards. Meeting minutes we reviewed showed that key messages were shared with ward staff.

Staff were encouraged to develop their skills in all areas within the service. Specialist training was provided which was specific for cancer services, such as training to administer chemotherapy medicines, administration of blood products, and various radiotherapy roles.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. However, not all staff or managers were aware of this. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

All staff were aware of the vision and values of the trust and were able to give examples of how their work reflected the values. However, not all staff reflected the values of the trust in their interactions with colleagues.

The service had a strategy to deliver cancer services. However, it was not clear whether staff on the frontline knew about the strategy and some leaders were unable to articulate clearly how the plan was going to be delivered.

The service had developed an initial strategy to address the staffing shortfall in the radiotherapy service and was working on a longer-term strategy to address the rise in demand for this service.

The interim strategy included:

- Continued recruitment.
- Improvement to staff experience, including trial of different working pattens.
- Funding to support staff development.
- Recruitment of operational leads to support change in structure and improve line management.
- Recruitment of a second training and education radiographer.

Work was underway with implementing the interim strategy whilst developing a longer term one. Leaders told us these measures were already starting to make some impact but that more time was needed to see sustained improvements.

The longer term plan was mainly focussed on staff retention; creating new opportunities for radiotherapy staff; developing new specialist roles; and including a clinical element to educational roles to add flexibility and resilience to the wider team.

There was a recruitment strategy which was ongoing to address the nursing staff shortage and other clinical roles. This included regular recruitment fairs, using a flexible and blended workforce to support the nursing role and recruitment and support of international health professionals, including radiologists.

The trust shared their recruitment strategy for 2023/24 which outlined several initiatives already taken to improve staffing levels and patient safety across the service. They had:

- Provided training for healthcare assistants to become nurse associates. Nurse associates were a new role within the nursing team. Nurse associates work with healthcare support workers and registered nurses to deliver care for patients and the public. This role is also a steppingstone to becoming a registered nurse.
- Recruited 2 therapy assistants to work closely with nursing and allied health professionals, such as physiotherapists and occupational therapists to promote independence and a faster recovery.
- Recruited 2 line technicians on each ward to focus on blood sampling and line care to enable blood results to be obtained earlier in the day to determine treatment and blood products faster.
- Recruited a clinical support nurse who focusses on supporting new starters with key clinical skills specific to cancer service.
- Provided ongoing clinical education to support all staff with skills and knowledge for cancer speciality.
- The Chemotherapy team provided support and education for staff to develop skills to deliver systemic anti-cancer therapy (SACT) through completion of a SACT passport.

There was an equality, diversity and inclusion (EDI) strategy but this was not well embedded within the trust and it was not clear that there was divisional and organisational learning from EDI issues that had arisen within the service.

Culture

Many staff did not feel respected, supported, and valued, although some staff in some departments did feel supported, respected and valued. Staff were focused on the needs of patients receiving care. The service provided opportunities for career development but did not consistently promote equality and diversity in daily work. The service did not consistently have an open culture across all services where staff could raise concerns without fear.

The culture appeared varied between wards and departments, and staff had mixed views about whether they worked in a positive culture. Many staff said they were able to raise concerns without fear and felt there was a supportive culture

within the service. However, numerous other staff felt they were not treated fairly, equally or with respect and were afraid to speak up. Some staff on one ward reported experiences of unfair treatment by managers and leaders and bullying among their colleagues with examples of disrespectful behaviour by some staff towards others. Also, within the radiotherapy department, some staff who were from an ethnic minority background said they had not been treated equally compared to their colleagues and expressed concerns about racist behaviours towards them.

Staff reported bullying from peers and senior colleagues, particularly for black and ethnic minority groups. This had resulted in staff feeling unsupported and not valued or respected. They told us that some very experienced staff had left the service due to bullying. Service leaders had conducted several investigations to address concerns raised by staff and had not been able to evidence any patient impact or substantiate some of the issues raised; although some were substantiated. Local leaders told us communication between staff was improving. However, staff still felt that the issues had not been fully resolved and they remained unhappy.

Staff working in the radiotherapy department had also reported unprofessional behaviours including bullying and harassment and discriminatory behaviours relating to ethnicity and race. They had also reported issues relating to unfair recruitment practices. Local and senior leaders had conducted investigations, including a culture review in 2021 and implemented a set of actions which included restructuring of the service to align the professional reporting lines into the nursing structure of the division and chief nurse at board level.

The senior leadership team were aware of the concerns in the radiotherapy department and in the last 18 months had conducted an internal investigation into complaints relating to allegations of racism and inequality. Leaders collected experiences from 77 out of 92 staff who responded to the survey and had implemented an action plan to address the issues they had identified. They also commissioned an external company to conduct a culture review so leaders could learn more about how to improve the culture around equality and diversity and in relation to the specific challenges experienced by minority ethnic staff. The trust had made changes which included restructuring the department and creating psychological safe spaces for people to talk about their experiences. They also commissioned an equality, diversity and inclusion course which focussed on adopting appropriate behaviours to build a positive culture.

Staff said they were aware of some issues that had been raised and acknowledged the actions taken by the senior leadership team but felt more needed to be done to improve some aspects of the organisation's culture. Some senior staff expressed concerns over the length of time taken to conduct the investigation and concerns that the issues may reappear.

There was a trust-wide 3 year inclusion strategy (2020) in place which had a series of objectives aimed at creating a healthy and inclusive culture whereby staff had the skills and confidence to have a voice, and enable partnership working. The strategy outlined a number of agreed deliverables to help achieve the goals. These included;

- An inclusion leadership programme for senior and middle managers.
- A leadership programme to improve leadership opportunities for ethnic minority staff.
- Increase diversity in leadership roles.
- Expand 'Hearts and Minds' – big conversation sessions for all staff to understand ethnic minority staff experiences and understand the impact of race inequalities.
- Develop Big Conversation sessions for all staff to improve understanding of disability, long term conditions, neurodiversity, and mental health.

Cancer services

The strategy outlined a number of proposed outcomes to demonstrate the success of the strategy over a 3 year period, however, it was not clear whether the outcomes were likely to be fully achieved, and we did not see any evidence of any positive impact on the cancer service.

Although there were strategies, working groups and task groups in place and action plans in progress, some senior staff within the cancer service felt that the trust had not invested or committed sufficiently in improving or integrating EDI strategies. Additionally, feedback showed the trust had not ensured enough ground level EDI presence or commit to sufficient follow up to prevent recurrence of EDI issues.

A survey conducted in 2022 for cancer services was responded to by 26% of staff from the haematology oncology and palliative care teams. This showed that scores in each area were below average for NHS trusts generally. In particular, 'staff morale' scored 5.5 out of 10 and 'we are recognised and rewarded' score 5.4 out of 10. The highest score was for 'we are compassionate and inclusive' which scored 6.9 out of 10.

The survey showed that staff working in the haematology service scored much lower than the trust average in satisfaction scores for most questions in the survey, except for 'feel my role makes a positive difference' where they scored slightly higher than the trust average. Scores for the oncology and palliative care team were similar to the trust averages.

Most staff told us they felt part of their immediate team and were included in meetings and decisions about the future. However, team meetings were infrequent and often cancelled due to a shortage of staff on most of the wards and services. Some staff who had experienced poor behaviour from colleagues did not feel part of the team and told us that many experienced staff had left the service due to inequalities, racist behaviour and bullying among staff which had not been resolved by local or senior leaders.

Despite the culture in which some teams worked, many staff told us they were proud to work for the trust and had a common sense of purpose. There was a collective responsibility between teams and services at ward level, where managers redeployed staff to ensure gaps were filled, and we saw many positive and supportive interactions between staff.

The trust had a Freedom to Speak Up Guardian and Freedom to Speak Up champions who were service level based. Staff were aware they could contact a champion or guardian if they needed to.

Staff were open and transparent when working with patients. When something went wrong, patients received an apology and were told about any actions to prevent something similar happening in the future.

Governance

Leaders operated governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities. However, not all staff had the opportunity to meet to learn and embed new processes. Senior staff had opportunities to meet, discuss and learn from the performance of the service.

There was a governance system in place where the trust used established systems, processes, and clinical policies in conjunction with The National Institute for Health and Care Excellence

guidelines to provide a set of standards for wards and departments to comply with during each stage of the patient's journey.

Cancer services

The senior leadership team reported into the executive board. Each of the cancer specialities held regular meetings to discuss performance, risk and quality, and presented to divisional quality and safety meetings on a quarterly basis. The service also used a clinical dashboard to share information and report on performance of key safety and performance indicators.

We reviewed a sample of meeting minutes for each speciality and divisional meetings and saw these were regular, comprehensive and covered a rolling agenda where risk, incidents, performance and quality were discussed. We also reviewed meeting minutes from matron meetings where we saw that key information was shared with staff.

The cancer service was spread across divisions and led by clinical specialists and operational leads. Monthly governance meetings took place where leaders discussed progress across the service.

Staff understood their roles and what they were accountable for. Each division reported key quality, safety, and performance information to the divisional board monthly. Regular governance, finance, performance, safety, quality, and risk meetings took place which fed into the divisional meetings. These were attended by medical and nursing leaders and included relevant staff at different levels.

Staff at ward level told us that key information was not always shared due to team meetings being infrequent. Therefore, we were not assured that learning from feedback and incidents was consistently actioned and embedded.

Management of risk, issues and performance

Leaders and teams used systems to manage performance but this was not always effective. They identified most risks and issues and identified actions to reduce their impact but this was not always effective.

Risks, issues and performance were discussed at trust board level, divisional level and service level and information was shared with staff at ward level via matron. Each cancer speciality maintained its own risk register, which included local level risks.

Across the cancer service, the top risks included staffing, absences, service interruptions due to staff shortages, increased waiting times for treatment, and staff vacancies.

The risks reflected most of the concerns described by staff across the service and at ward level, however, there were some key omissions that we identified during our inspection. For example, culture and staff discontent in some parts of the service.

Ward managers conducted audits and checks and monitored performance which they reported to their matrons. Performance measures were also shared with staff at meetings and visually on a dashboard. However, many frontline staff were unaware of ward or service performance and felt they did not have enough time to attend team meetings when they were scheduled or to read all their emails.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Cancer services

Staff had access to up-to-date, accurate, and comprehensive information on patients' care and treatment and used this consistently. Patient data was updated electronically, such as the recording of physiological observations and medicines administration. Staff were aware of how to use and store confidential information.

Managers used dashboards to manage and share performance metrics and audit outcomes with senior leaders.

Notifications were made to external organisations when required.

Neurosurgery

Requires Improvement

Is the service safe?

Requires Improvement

This service has never been inspected before. We rated it as requires improvement.

Mandatory training

Not all staff completed mandatory training in key skills.

Not all staff had completed up-to-date mandatory training. Fire safety training had been completed by 79% (155) of the 197 eligible staff within the neurosurgical department. Information provided by the service demonstrated that department D1 neurosurgery had 45 eligible staff required to undertaken fire safety training. Of these, 23 (51%) had completed the training. It was unclear from the information provided by the service which area of neurosurgery this related to, whilst 71% (32) of the eligible 45 staff on ward 409 had completed information governance training. This was not in line with the trust target of 90% and meant the service could not be assured that staff knew or understood what was required of them.

Information provided by the service highlighted that not all clinical staff completed training on recognising and responding to patients with learning disabilities, autism and dementia. The Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role.

The Oliver McGowan Mandatory Training on Learning Disability and Aiming to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability.

Ward managers supported staff to attend face to face training sessions by advertising for bank staff to backfill vacancies created by training courses. However, compliance levels remained below the trust target of 90%.

Safeguarding

Staff understood how to protect patients from abuse but not all had completed training on how to recognise and report abuse.

Not all staff received training specific for their role on how to recognise and report abuse. Of the 40 staff within the neurosurgical department, 25, (63%) had completed safeguarding adult and children level 2 training. Of the 95 ward staff eligible, 71 had completed the training required. This was a concern given a large proportion of patients cared for by the service had a high level of dependency and vulnerability due to the nature of their illness.

A safeguarding team within the wider organisation provided additional support and guidance if required. Staff that we spoke with during the inspection told us there were “no issues” in seeking support from the team.

Staff could give examples of how to identify adults and children at risk of, or suffering, significant harm and there was a clear process for escalating concerns easily accessible to all staff.

Neurosurgery

Cleanliness, infection control and hygiene

Staff did not always control infection risk well. The service did not consistently use systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Staff mostly followed infection control principles including the use of personal protective equipment which was readily available. However, staff within 1 theatre were noted not to be wearing theatre hats within the operating room. This was not in line with the National Institute for Health and Care Excellence (NICE) Clinical Guideline 74 'Surgical site infections prevention and treatment'. This was highlighted to a senior member of staff and rectified immediately.

Hand hygiene was monitored and showed staff were improving with this; although still not achieving the trust target for compliance. In February 2023; on 1 neurosurgery ward; an audit demonstrated compliance of 65% (76/116) to effective hand hygiene principles. In April 2023, this had improved to 76% compliance (105 out of 138). This meant not all staff were decontaminating their hands in line with NICE clinical guideline 61. Leaders had identified hand hygiene as a strategic aim within the divisional infection prevention and control committee minutes and this was discussed monthly.

Ward areas including the sluice were clean and had suitable furnishings which were clean and well-maintained. At the time of the inspection the theatre cleaning schedule and the deep clean maintenance schedule were reviewed and in line with national guidance.

Hand washing and sanitising equipment was available along with face masks at the entrance of each ward. Patient information was clearly displayed at each entrance guiding people on how to effectively clean their hands.

At the time of the inspection, information provided by the service demonstrated that surgical site infections were not monitored. A proposal had been put forward to the infection, prevention and control group to monitor specific indicators relating to surgical site infections including readmitted post-surgical wound infections. However, this was not yet in place meaning the service did not know the number of surgical site infections, could not tell whether they were an outlier nor improve practice to support a reduction in surgical site infections.

Information provided by the trust demonstrated that although the service did not conduct antimicrobial audits or collect antibiotic consumption data, post infection reviews were undertaken and considered antimicrobial prescribing history.

Monitoring of screening compliance for Methicillin-resistant Staphylococcus aureus (MRSA) upon neurosurgical wards in April 2023 demonstrated that 94%, 103 out of 111 patients had been screened appropriately for MRSA.

All patients were screened for COVID-19 on admission and an electronic dashboard on each ward indicated the infection status of each patient. Patients suffering from an infection of any type were discussed within theatre scheduling meetings and adjusted on each theatre list to accommodate. Air exchange was considered along with deep clean requirements.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. However, staff did not always have access to sufficient clinical equipment. Emergency resuscitation equipment for theatres was not easily available or checked appropriately. Staff were trained to use equipment. Staff managed clinical waste well.

Neurosurgery

Patients could reach call bells and during the inspection staff responded quickly when called.

The service did not always have enough suitable equipment to help staff safely care for patients. There was a defined process for ordering clinical equipment, however, staff told us that divisional sign off was required and this could slow the ordering process down. In addition, key equipment could not be ordered in bulk and often took more than 7 days to arrive; this meant that the service often ran at stock levels with low spare or back up capacity. For example, at the time of the inspection, a particular type of irrigating forcep used in theatres had run out, a new order had been placed but had not yet arrived and so staff were required to use an alternative piece of equipment.

Medical equipment was recorded on a maintenance service schedule. Equipment was labelled to show portable appliance testing and calibration checks had been completed. Consumable equipment (single use) was sample checked and all were in date and rotated where appropriate so that consumables due to expire were used first.

The service did not have a dedicated resuscitation trolley in its neurosurgical theatres, the nearest one was outside a different theatre along the corridor. When this trolley was reviewed during the inspection, it was found to be visibly dusty and the checklist was not completed appropriately. Resuscitation trolleys within ward areas were easily accessible and checked daily ensuring that all equipment was available, in date and in service.

Staff disposed of clinical waste safely and there were regular collections of both clinical and domestic waste. A sharps policy was in place and easily accessible to all staff; this set out what to do in the event of an accidental needlestick injury.

Ward areas were tidy and uncluttered, corridors and fire doors throughout the service were free from obstruction. Patient areas, such as wards and theatres, were secure with a swipe access intercom system and there were signs instructing patients and relatives not to allow access to others.

A service level agreement was in place for sterile services which were collected daily.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks. However, not all risk assessments were updated as per national clinical guidance. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool, the National Early Warning Score (NEWS) 2 to identify deteriorating patients. There was a clear process for escalating patients who were at risk of deterioration. A sepsis screening colour coded box flashed up on the electronic records along with an alarm if the NEWS2 (which was automatically calculated by the prescribing information and communication system) was elevated. This advised staff of when to carry out the next set of clinical observations and who to escalate them to; a score of 7 or above automatically alerted an outreach team who then contacted the ward via telephone and then attended in person.

An acuity measurement tool was used in ward areas to assess the level of dependency of each patient so that they could be cared for by the appropriate staff.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. A World Health Organisation (WHO) surgical safety checklist was completed for all surgical

procedures within the service. The checklist included time out and stop criteria along with a sign out checklist which included checking that all instruments, swabs and sharps counts were correct, intravenous cannulas had been flushed with sterile water and all relevant medication had been prescribed. This was in line with the WHO 5 steps for safer surgery requirement.

Staff that we spoke with had an awareness of and followed the local and national safety standards for invasive procedures (recommendations to improve safer care for patients undergoing invasive procedures). Local safety standards for invasive procedures relating to an insertion of a tracheostomy (a hole in the patient's airway to help the patient breathe) and vascular (into a vein) access were reviewed; they were in date and contained the appropriate information for undertaking each procedure.

Staff knew about and completed risk assessments for each patient on admission which included a skin assessment by completing an electronic body map and a falls risk assessment. We looked at 9 sets of records and they were all complete. They also completed a venous thromboembolism (VTE) assessment for each patient both on admission and as part of the surgical checklist; this was a checklist to assess the patient's risk of developing blood clots. National Institute for Health and Care Excellence guidance (NG89) March 2018, states that all patients should be assessed and have a reassessment for VTE at the point of consultant review or if their clinical condition changes. We looked at 9 sets of VTE records and found that only 1 patient had had a reassessment of their VTE; most had only had an assessment on admission to the ward. This did not follow national guidance. The VTE policy for the service was out of date and did not set out when patient needed their preventative treatment reviewing. This was despite significant work being undertaken by the trust following an avoidable patient death post neurosurgery in 2019 linked to VTE, which prompted a quality improvement project.

Staff shared key information to keep patients safe when handing over their care to others, ward handovers took place at 7am and 7pm daily and were attending by all staff.

Shift changes and handovers included all necessary key information to keep patients safe. Daily surgical handovers were undertaken at 8am each day including weekends. The theatre list for the day along with all surgical cases were reviewed and prioritised with consultants and anaesthetists in attendance.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough nursing and support staff to keep patients safe. Data showed that between the 8 to the 18 April 2023, 249 hours of registered nursing shifts were unfilled by substantive staff. Of these, 36% were filled by bank staff leaving 159 hours unfilled. Healthcare assistant and trainee nursing staff had 359 unfilled hours by substantive staff and of these, 84% were covered by bank staff, leaving 40 hours unfilled.

Safer staffing information provided on the wider trust website demonstrated that on ward 409, in May 2023, of the 2,527 total monthly planned staff hours for registered nursing staff the actual total monthly staff hours was 1,845 (73%). This at times meant there were 3 registered general nurses on duty overnight, which meant there was a ratio of 1 nurse to 16 patients. Staff that we spoke to told us this was very difficult due to the level of care some patients that had undergone neurosurgery required. Unsafe staffing levels were highlighted upon the risk register for the service.

Neurosurgery

The board of directors did an unannounced visit to the ward in September 2022. They were concerned that the team were stretched, regularly understaffed and heavily reliant on temporary staffing support. However, we saw little evidence of action following this visit. Staff told us they managed to complete essential clinical tasks but did not have time to provide more general care to patients.

Managers used bank staff to fill vacant shifts and requested staff familiar with the service. Bank staff were given a local induction if required and had access to electronic reporting systems, such as the electronic patient record. No agency staff were used within the service.

The trust was undertaking active recruitment to mitigate nurse staffing vacancies. A trainee nurse associate project was in place within the service and there was a rolling recruitment advert for band 5 and 6 registered general nurses. Military support in terms of healthcare assistants and registered general nurses from the local military hospital were used often for healthcare assistant roles.

Ward managers met with flow co-ordinators 3 times each week to review staffing levels against the level of care each patient required. This meant that managers could adjust staffing levels according to the needs of patients and ensure those areas with higher levels of need were prioritised for nurse staff when staffing was reduced.

The service had a registered nursing vacancy rate of 11.49 whole time equivalent in May 2023 and a healthcare assistant and trainee nursing associate vacancy rate of 2.43 whole time equivalent.

Sickness rates for the service were mixed. Registered nursing staff on 1 neurosurgical ward had an average of 7% absence between March 2022 and March 2023. Additional clinical services on the same ward had a 12 month average absence rate of 9% whilst theatres registered nursing absence rate over the same period was 4%. The service did not provide information around what its sickness absence target was.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have enough medical staff to keep patients safe. There was a single neurovascular surgeon within cranial surgery which did not meet the invited review mechanism (a partnership between the Royal College of Surgeons, the Surgical Specialty Associations and lay reviewers representing the patient and public interest which provides independent expert advice to the trust) recommendations of 2 consultants. This meant the service did not have a sustainable working model or an ability to backfill a deficit in the event of unplanned absence meaning that cases were put on hold during periods of absence if a locum neurovascular surgeon was not available. A total of 18.9 whole time equivalent consultants were required across all neurosurgical disciplines including spinal, oncology and neurovascular. At the time of the inspection, information provided by the service demonstrated that 16 whole time equivalent consultants were in post however, the information did not demonstrate which disciplines of neurosurgery these related to.

Between the 10 and 24 April 2023 the service used locum cover on 57 occasions; 36 were bank shifts and 21 were agency cover.

Neurosurgery

Consultant cover was available on site from 8am to 5pm during weekdays and 9am to midday at weekends, and on call cover was provided outside these hours. A 2-tier registrar on call system was also in place, tier 1, first on call was required to be onsite and dealt with external referrals, this was a 1 in 6 day on call rota along with the tier 2, second on call who dealt with theatre emergencies.

Consultant cover was available on site from 8am to 5pm; and on call cover was provided outside these hours.

There were 4 physicians associate who supported the service. Physician associates are medically trained, generalist healthcare professionals, who work alongside doctors and provide medical care as a part of the multidisciplinary team. Physician associates are practitioners working with a dedicated medical supervisor but can work autonomously with appropriate support. However, physician associates cannot prescribe medicines or request ionising radiation scans such as X-Rays or CT scans.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, mostly up-to-date, and easily available to all staff providing care. However, daily care plans were not always completed.

Patient notes were comprehensive, and all staff could access them easily. During the inspection, 12 sets of patient records were reviewed. These demonstrated that staff completed allergy information and most risk assessments in line with national guidance.

Daily care plans were not always completed. Staff were required to complete a daily care plan twice a day, which was once per shift. We looked at 12 sets of records and found that out of a total of 49 days where the staff should have completed the care plan twice a day, it was done only once for 8 out of the 49 days; this meant there were gaps in the recording of respiratory, neurological, nutrition, mobility, and toileting care plans. The risk register for the service had listed a delay in care needs due to the number of nursing vacancies as a risk.

Patient notes were mostly electronic which meant they were easily to read. Those that were written were legible and the clinician was identifiable. Consent and safety checklists had been completed as well as preoperative information.

Medicines

The service did not always use systems and processes to safely record and store medicines.

Staff did not always complete medicines records accurately or keep them up-to-date. During the inspection we saw that controlled drugs checks within the neurosurgical theatres were not completed at weekends if the theatre was not in use. This was not in line with the Royal Pharmaceutical Society Professional Guidance on the administration of medicines in healthcare settings. In addition, daily checks had not been completed on 5 occasions between the 7 February and 11 April 2023.

Staff followed systems and processes to prescribe and administer medicines safely. We looked at 9 patient medicine records. We found that allergies were documented and all medication was given as prescribed. Where there were missed doses, there were clear reasons for this documented, such as a contraindication. We saw that antibiotics were prescribed and reviewed in line with national guidance.

Neurosurgery

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Concerns, incidents and near misses were reported in line with the trust policy. Staff told us the most common type of incident was patients falling within the service. We were told that post-surgical amnesia was common and therefore patients were cared for in bays of 4 beds so that staff could monitor and quickly assist them if needed.

The service had 1 never event between April 2022 and April 2023; this was a retained swab. Staff were aware of this incident. At the time of the inspection a review was being undertaken. Managers had shared the most up to date learning about the never event with staff locally and across the wider trust.

Staff reported serious incidents clearly and in line with trust policy. Learning from incidents was shared both within the service and across the wider trust. Following a serious incident within the neurosurgery service, learning was shared in the trust wide 'lesson of the month'.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. An electronic prompt was loaded onto the incident reporting system which prevented further progression of an incident investigation until formal duty of candour had been undertaken.

There was evidence that changes in the service had been made because of feedback after incidents. Local root cause analysis had been completed for skin damage incidents and the learning had been shared with all staff. A skin damage board was displayed, and staff had undergone local training with a practice educator and tissue viability nurse in response. The information provided did not demonstrate whether the service had seen a fall in the number of pressure wounds however, meeting minutes from the April 2023 clinical governance and patient safety meeting demonstrated that no serious incident investigations were undertaken for pressure wounds.

Is the service effective?

Requires Improvement

This service has never been inspected before. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment which was based on national guidance or evidence-based practice.

At the time of the inspection inconsistency in the use of the amino acid 5-aminolevulinic acid (5-ALA) was highlighted by staff; this was a pink drink which was used to help neurosurgeons see and remove a brain tumour during surgery. Decisions around the use of this adjunct were largely made around surgeon preference rather than through evidence based multidisciplinary team meetings.

Neurosurgery

Staff did not follow national guidance (National Institute for Health and Care Excellence clinical guideline 89 March 2018) regarding re-assessment for venous thromboembolism (VTE). The trust VTE policy was also out of date. See 'assessing and responding to patient risk' section in 'safe' for further detail.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patient told us the food was "ok".

Staff fully and accurately completed patients' fluid charts when needed however, nutrition charts recorded as part of the daily care plan were not always completed. Please see records section under safe domain for further details.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The Malnutrition Universal Screening Tool (MUST) was used to screen all patients upon arrival and then repeated weekly to identify patients at risk of malnutrition. A dietetic referral could then be made, and strategies put in place to support the adequate nutrition of the patient. Patients with difficulties in swallowing were referred to the speech and language therapy department for specialist assessment.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. An audit of pain assessment demonstrated that in April 2023, 96% of patients had clinical observations and pain scoring recorded every 6 hours in line with the trust pain relief policy.

During the inspection we saw that patients received pain relief soon after requesting it and staff prescribed, administered and recorded pain relief accurately. This included prescribing pain relief medication prior to leaving theatres so that the patient could receive the amount of pain relief they needed when they needed it.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

Managers and staff carried out a programme of repeated audits to check improvement over time. Audits including complication rates were monitored monthly. Managers used audits to evaluate key elements of treatment, such as anticoagulant administration, so that the service could assess whether there was a contribution to complications, such as postoperative pulmonary embolism (a clot in the lung). A missed enoxaparin (blood thinning medication) audit demonstrated that 8% of patients between November 2022 and April 2023 had missed this medication. The audit however, did not give wider context including the total number of patients the audit referred to and the reasons for the missed dose. Learning from the findings was shared across the trust in the lesson of the month newsletter.

Observational World Health Organisation checklists were completed within theatres which included neurosurgery but the data could not be determined specifically which results related to neurosurgery.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Mortality statistics were monitored each month and internal reviews of mortality indicators alongside the learning from deaths programme were undertaken. The outcomes of these findings were reported to the clinical quality monitoring group, clinical quality and patient safety committee, trust board and integrated care board quality committee so that both internal and external oversight was maintained.

Monthly mortality and morbidity meetings were widely attended by junior doctors, registrars and consultants. There was a rota for case presenting so that each month a different team took the lead. Deaths and morbidities including readmissions and returns to theatre were considered.

Competent staff

Staff were competent for their roles. However not all staff received an appraisal to provide support and professional development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Not all staff received yearly, constructive appraisals of their work; Information provided by the service demonstrated that in April 2023, the appraisal rate for the service was 71% against a trust target of 90%. Of the 34 staff eligible on ward 409, only 9 had received an appraisal at that time (26%). Of the 32 theatre staff, 23 (71%) had received an appraisal whilst 28 of the 41 (68%) of non-trainee medical staff had received their annual appraisal. Managers told us the low appraisal rate was due to the COVID-19 pandemic; but they were working to achieve the trust target for appraisals.

No formal mentorship programme was in place for newly appointed senior medical staff however trainee staff that we spoke with during the inspection felt there had been improvements in training. At the time of the inspection trainee doctors had been reinstated within the service following a period of removal due to bullying and poor culture.

Daily teaching sessions were in place for junior doctors, a different case was discussed at the end of handover and doctors were supported with preparation of examinations. Registrars felt they were able to gain the right level of experience for their stage of training based on the volume and variety of patients.

The clinical educators supported the learning and development needs of staff. Registered nursing staff were supported in accessing an accredited neurosurgical course at a local university whilst non-registered staff, such as health care assistants were supported with in-house service specific training. Staff widely felt that managers did not identify or address poor staff performance promptly or support staff to improve. We were given examples of when staff had highlighted areas of concern to their managers such as staff repeatedly cancelling clinics, block booking specific time out and failure to take responsibility for specific cases when on call but they were not acted upon.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. During the inspection we saw that staff from the service worked closely with intensive care and high dependency colleagues and each area supported the others as needed. Quarterly meetings were held between the areas.

Neurosurgery

A clinical nurse specialist offered support and guidance to staff in caring for patients lacking mental capacity. Information on the service internet site demonstrated that plastic and reconstructive surgeons, radiologists, audiologists, occupational therapists, speech and language therapists and physiotherapists formed part of the multidisciplinary team supporting patients with their care and treatment.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including during weekends. Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, 7 days a week. Consultant cover was a mixture of both onsite and on call. A 2-tier registrar on call system was also in place, tier 1, first on call was required to be onsite and dealt with external referrals, this was a 1 in 6 day on call rota along with the tier 2, second on call who dealt with theatre emergencies which could be accessed 24/7.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had information promoting healthy lifestyles and support on wards including smoking cessation, signposting to charities relating to injury, illness, and trauma to the brain.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

No staff were trained in the Mental Capacity Act or Deprivation of Liberty Safeguards. However, staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Information provided by the service did not indicate that staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Information on the wider trust internet site suggested that this training was included within safeguarding adults level 3 training, which was not completed in the service according to the data provided. This was not in line with Skills for Health Core Skills Framework and meant that the service could not be assured that all staff did know how to care for a patient who lacked mental capacity.

Staff that we spoke with during the inspection understood how and when to assess whether a patient had the capacity to make decisions about their care and gained consent from patients for their care and treatment in line with legislation and guidance. They knew how to access the policy to get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. When patients could not give consent, staff made decisions in their best interests. Staff that we spoke with could describe and knew how to access the trust policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff made sure patients consented to treatment based on all the information available. This included a preoperative assessment and could give examples of fluctuating capacity also.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete applications to submit to the local authority. There was a safeguarding clinical nurse specialist that supported staff and offered guidance when required. All patients requiring 1 to 1 care, were reviewed for mental capacity and Deprivation of Liberty Safeguards applications made if required.

Neurosurgery

A record review of patients needing urgent Deprivation of Liberty Safeguards was undertaken by the service and during the inspection we saw that the correct assessments had been carried out and the processes followed to ensure that patients were cared for in their best interest. Between November 2022 and April 2023, 68 Deprivation of Liberty Safeguards applications were made within the service.

Is the service caring?

Good

This service has never been inspected before. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity.

Staff were discreet and responsive when caring for patients. We saw that staff took time to interact with patients and those close to them in a calm, respectful and considerate way.

Patients said staff treated them well and with kindness. One patient we spoke with said they felt that staff provided good care and a relative of one patient described staff as "golden".

Staff followed the service policy to keep patient care and treatment confidential.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw numerous examples during the inspection of staff talking kindly and compassionately to patients and their relatives, taking time to explain the current situation and supporting both patients and relatives when they were distressed. We saw follow ups to these conversations, where patients and relatives were 'checked' upon to make sure they were ok. This demonstrated that staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

During the inspection we saw that staff talked with patients, families and carers in a way they could understand, using communication aids such as pictures where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. In April 2023, 93% of 39 respondents gave positive feedback about the service.

Neurosurgery

Is the service responsive?

Requires Improvement

This service has never been inspected before. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service did not always provide care in a way that met the needs of local people and the communities served.

Services were not always planned or organised to meet the needs of the local population. An absence of the deep brain stimulation service meant that patients were not treated locally. There were extended waiting lists due to poor staffing levels in skull based, epilepsy and oncology surgery; this meant that patients could be transferred to other providers.

The hospital was easily accessible via public transport. A free shuttle bus was available for patients and relatives from the local train station. Neurosurgical services were located upon the fourth floor of the building which could be accessed via lift or stairs. Directions to the ward from the main entrance were located on the wider trust website meaning that patients, relatives and visitors could predetermine how to get there.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Information provided by the service demonstrated there had been no mixed sex breaches between October 2022 and April 2023 and the integrated quality report did not record any mixed sex breaches between January 2021 and September 2022.

A relatives' room within the service had several chairs and settee. There were also posters of support groups that relatives, carers and friends could access.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs. Staff made reasonable adjustments where they could do to help patients access services.

The service was not compliant with the Accessible Information Standard (AIS) which is a leal requirement for healthcare providers since 2016 and says that people who have a disability or sensory loss should get information in a way they can access and understand to reduce health inequalities. The service did not have a policy or procedure for staff to follow regarding the AIS. Whilst the trust did have an action plan to implement the AIS from June 2022; there was no evidence that the neurosurgery service was able to consistently identify people who may need adapted communication; or have sufficient communication tools on hand to enable people who required adapted communication to get information about their care or treatment.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Whilst the wider trust internet site provided information about a learning disability and autism toolkit which contained items such as hearing aid amplifiers and magnifying glasses, this was available to staff within the neurosurgical services when required.

Interpreters and signers could be accessed both telephonically, electronically and face to face.

Patients were given a choice of food and drink to meet their cultural and religious preferences, including African-Caribbean, Kosher and Halal and Asian style vegetarian meals.

Patient orientation boards were displayed in each ward however, on one ward the date displayed was the 23 April whilst on another it was the 21 April; the actual date was the 24 April. This was important because patients undergoing or awaiting complex brain surgery could often be confused and disorientated. The purpose of the board was to help the patients in understanding their surroundings when reliant on the information displayed.

Access and flow

People could not always access the service when they needed it to receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national comparisons.

Managers held weekly scheduling meetings and there was a dedicated neurosurgery booking team. The meetings reviewed cancellations, later starts, early finishes and theatre utilisation.

A dedicated flow coordinator produced a report 3 times daily so that managers could track the information as closely as possible and use it to inform the bed meetings which took place multiple times a day.

Managers monitored waiting times and made sure patients could access emergency services when needed and receive treatment. However, there were no ringfenced urgent clinic spaces which meant that consultants often had to fit urgent referrals into the end of a clinic session. This created additional workload, pressure and time constraints for staff involved and meant the service did not have a robust mechanism to prioritise urgent referrals.

In April 2023 of the 1,377 patients awaiting treatment, 857 (62%) were waiting less than 18 weeks whilst 75 (5%) waited over 52 weeks. This was in comparison to 7% of people waiting 52 weeks nationally. Of the patients that started treatment in April 2023, 129 (71%) had waited less than 18 months compared to 64% nationally and 19 (10%) had waited over 52 weeks compared to 10% nationally.

In addition, there was a lack of consistency in monitoring potential gaps in patient flow through the service. An on call consultant reviewed an incoming referral and undertook the initial patient assessment, the patient was then booked into clinic and seen by a different consultant. Then, if treatment was required the patient was booked onto a theatre list with a different consultant yet the caseload still sat with the original consultant.

Managers worked to minimise the number of surgical patients on non-surgical wards. The service had recognised that medical outliers from the wider trust were limiting the neurosurgical bed capacity. These beds were not ringfenced and often, staff told us, would be allocated to a medical patient outside of office hours. This caused an increased number of operations to be cancelled and could lead to patient safety issues if there was no bed available post-surgery. No formal standard operating procedure was in place to formalise decision making and nursing staff told us that they had no input into the decision being made. In response to this the service had introduced admitting all patients to the surgical ward the night before the procedure.

Managers worked to keep the number of cancelled operations to a minimum and reviewed the data regularly. Between February and April 2023, 116 patients had their surgery cancelled on the day of the planned procedure. Of these, 39 were due to no bed being available either on the ward or in intensive care. Another 10 were due to the patient being unfit for

anaesthetic. Information was not provided by the service about how it then worked to rearrange them as soon as possible and within national targets and guidance. National data demonstrated that between April 2022 and April 2023, 3,368 operations were cancelled. Of these 1,600 (48%) were reported as a breach of standard (where the patient had not been treated within 28 days of a last-minute cancellation) this was greater than the 23% national beach level for the same period.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

Managers investigated complaints and identified themes. The service had received 35 complaints between June 2022 and May 2023. Of those, 9 related to a delay in treatment or clinical assessment, 4 were related to delay or failure to undertake an x-ray or scan and 4 related to poor staff attitude. At the time of the inspection, 18 examples of complaints were provided by the trust. Of the 18, 6 had been completed and closed whilst the rest were under investigation. One complaint was described as an unwitnessed fall and patient care not being monitored. The 'current' stage of the complaint investigation following the inspection in April 2023 was "comments requested" despite it being received on 24 January 2023.

Patients, relatives and carers knew how to complain or raise concerns, information about how to complain was displayed throughout the unit and on the internet website of the trust.

Is the service well-led?

Inadequate

This service has not been inspected before. We rated it as Inadequate.

Leadership

Leaders had not acted to address or manage the priorities and issues the service faced. They did not support staff to develop their skills and take on more senior roles.

There was little evidence of clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership within the service. The service did not have a development programme including a consultant mentoring programme designed to support and develop future talent and there was little evidence of succession planning.

Less experienced consultants were not always effectively mentored in specific areas, such as skull based surgery, and leaders had failed to act and address the cultural issues within the service; these were first identified by the Royal College of Surgeons review in 2020 which found “deep routed relationship issues between consultants” and also found during this inspection process. Leaders within the service told us that an external company was to be appointed to support the trust with responding to the challenges within it however, this had not been confirmed by the wider trust and no terms of reference had been set at that time. Staff that we spoke with during the inspection told us leaders often failed to reply to emails and concerns they had raised both within the service, division and to the executive leadership team of the trust.

Neurosurgery

Several members of staff told us that managers within the department were not supported by the executive team. Examples of this included, little or no response to email correspondence, poor visibility in the service and failure to share key findings, such as the Royal College of Surgeons 2020 review.

Vision and Strategy

The service had a strategy to support in place. Some staff were unclear how the service would be developed or invested in.

The neurosurgery service strategy 2022 to 2024 set out a vision of building healthier lives, the right care in the right place at the right time with the right resource. Its strategic priorities included a patient safety focus running through the service, new workforce models and support for the health, wellbeing and development of the workforce.

The 3 year strategy was broken down by emergency, elective cancer, step down rehab and workforce and governance. Outcomes and key performance indicators to support this included substantive workforce, reduced length of stay, referral to treatment improvement and appropriate workforce/bed base against demand. Although the strategy was further broken down into success measures, dependencies and enablers there was little detail to demonstrate what was required to achieve these goals. For example, it listed robust recruitment and retention, vacancy reduction and substantive workforce but not how it was going to achieve them.

Staff within the service had little or no knowledge of the vision and strategy and some staff felt there was no projection of future demand, theatre space planning, planning of services offered or recruitment. They indicated there had been no structured planning process nor collaboration with staff, meaning that quality and sustainability could not be the focus of attention within the service. Staff were unclear about the future of the service.

Culture

Staff did not feel respected, supported or valued. Tensions between the team meant that focus on the needs of patients receiving care was not always paramount. The service provided little opportunities for career development. The service had a culture where staff struggled to raise concerns without fear.

During the inspection we saw a mixed picture in terms of staff feeling respected supported and valued. In the neurosurgical wards, staff told us that they supported one another and worked as a team. During the inspection, we saw a strong sense of teamwork. For example, staff volunteered to collect medications from pharmacy, 1 doctor collected a patient from the imaging department and several staff checked on a member of staff who was pregnant.

However, amongst medical staff within the theatre environment, interpersonal tensions amongst consultant team members specifically, meant there was a widespread level of animosity between medical staff and a lack of cohesive focus upon patient care. We heard examples of domineering characters taking over meetings, theatre lists and outpatient appointments with little or no challenge from leaders.

All staff that we spoke with were aware of such tensions and many talked about an unfair distribution of workload whilst others described the culture as toxic. The2022/23 staff survey for neurosurgery saw a very low return rate of just 17%.

Staff throughout the service told us they did not feel able to raise concerns for fear of bullying and retribution. There was little confidence in the whistleblowing and freedom to speak up processes and staff did not feel supported or listened to by the leadership team either locally or throughout the wider trust.

Neurosurgery

Governance

Leaders operated a governance process within the service however, we were unable to ascertain its effectiveness. Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.

Although there was a defined governance process within the service it did not always operate effectively. Meetings were not always well attended, and key information was not always widely available to all staff. Regular band 7 registered nursing meetings were chaired by the theatre matron and monthly divisional quality meetings were held along with weekly triumvirate meetings.

Managers monitored an electronic clinical dashboard. This provided information in real-time to leaders around the completion of key elements of care, such as clinical observations, pain relief monitoring, nutritional assessments and electronic wrist band checks.

Meeting minutes from a quarterly specialty management meeting were sent by the service. These reviewed compliance of national institute of health and care excellence guidelines, clinical guidelines for review, external peer reviews and compliance framework. Patient safety alerts and actions from investigations.

Management of risk, issues and performance

Leaders and teams identified and escalated some risks and issues but did not always complete actions to reduce their impact.

The risk register for the service contained 10 risks. Each risk had an action description, summary of progress and date for revision or completion. Risks included staffing levels, a single vascular surgeon and no skull based clinical nurse specialist, lack of bed capacity and risk deterioration due to lengthy waiting lists. First line managers within the service were not always aware of what the risks were upon the register and mitigating actions were not always robust. For example GPs directly escalate patients that return to them in pain or raise concern about the length of wait.

The wider trust had a process for reviewing harm. The wider trust process asked patients whether they wished to remain on the waiting list and relied upon the patient presenting to the emergency department or through their general practitioner if symptoms worsened.

The service did not have a clear oversight of patient caseloads of staff that were absent or on restricted duties. Although it had recognised the risk of only employing 1 neurovascular surgeon, there were no mitigating actions in place and the action of "advertise for a locum consultant with a view of substantive after period" was not due until 15 June 2023 as a fixed term contract, despite being initially highlighted in 2020. This meant that there was no effective plan in place for recruitment and the risk was therefore managed by locum which did not provide long term sustainability.

The service had a business continuity plan in place and arrangements were in place with the wider trust to share important information from the Medicines and Healthcare products Regulatory Agency central alerting system, so that they received medical device and medicine alerts which may be relevant.

Information Management

The service collected reliable data and analysed it. Staff could find the information that was available, in easily accessible formats. However, not all information required policies and procedures were in date or had been created. The information systems were integrated and secure.

Records were secure and password protected, and information technology included encryption and firewalls in line with data protection regulation.

The service had a Caldicott guardian, and all staff had to complete mandatory data protection training. Staff that we spoke with understood data protection.

Information was accessible to staff including available policies and processes, referral processes and patient records. However, others were out of date, such as the Venous thromboembolism policy and others such as the accessible information standard policy not in place. Staff we spoke with during the inspection told us there were enough computers to access their work without causing delay or impacting upon patient care.

Engagement

Leaders and staff engaged with patients, staff and the public.

The service hosted the brain tumour education and research patient and public involvement group in October 2022. This was held in conjunction with the local university and offered 'tips and tricks' to support patients and carers with cognitive changes and brain tumours. The meeting was attended by various brain charities, as well as patients, relatives and carers. The purpose of the meeting was to provide a support network, better understand patient experience and also to improve clinical care by facilitating research for people living with brain tumours.

The wider trust completed an annual staff survey and data was extracted to demonstrate neurosurgery responses. For the 2022/23 staff survey the response rate was 17.6%, out of 170 eligible to complete the survey, 30 responded. Of those, 3% (a 45% decrease from 2021) said they felt they had realistic time pressures. The information which the service provided stated that an action plan would be devised at the next governance meeting. Staff had attempted to engage with the service in highlighting concerns, face to face discussions and emails to leaders. Information provided by staff was that little or no response was received.

The service engaged with the general public via an online social media platform.

Learning, continuous improvement and innovation

Leaders encouraged innovation and participation in research.

The service demonstrated several innovations with which it was involved, including a whole genome sequencing for patients with brain tumours, day case biopsy for supratentorial brain tumours and the implementation of a new cauda equina syndrome pathway. Other initiatives were underway and being developed across the neurosurgical services.

Birmingham Heartlands Hospital

Bordesley Green East
Bordesley Green
Birmingham
B9 5SS
Tel: 0121244200

Description of this hospital

Birmingham Heartlands Hospital is an acute general hospital in Bordesley Green, Birmingham. The hospital is part of University Hospitals Birmingham NHS Foundation Trust and is based on a large site in a purpose-built facility. Birmingham Heartlands Hospital provides a range of outpatient, inpatient and emergency care services for its local community. These include maternity services, services for children and young people, medical services and surgical services.

We completed unannounced visits of the Urgent and Emergency Department due to information of concern. We also completed a follow up to the Pregnancy Assessment Emergency Room within the hospitals maternity services.

Urgent and emergency services

Requires Improvement  

Is the service safe?

Inadequate  

Our rating of safe stayed the same. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff. However, not everyone had completed it.

Not all staff kept up to date with all their mandatory training. The trust target of 90% for staff completion of mandatory training was not met. For example, 225 out of 335 eligible staff had completed fire awareness training (67%).

Training compliance for information governance was 72%. Out of 335 eligible staff, 242 staff had completed this. The trust target for mandatory training compliance was 90%.

Medical and nursing staff were provided with life support courses. These included Advanced Life Support (ALS) and European Paediatric Life Support. This training was provided for advanced clinical practitioners, consultants, emergency nurse practitioners, and nurses and should be renewed every 4 years. Out of 66 eligible staff, 36 were out of date (54%).

To mitigate the risk to children attending the service, the trust told us there was always a senior clinician certified to provide advanced paediatric life support on duty. The trust target of 90% was met for the following training: corporate and local induction, inclusion and diversity, infection prevention control (IPC), manual handling and resuscitation awareness.

Both nursing and medical staff were required to complete sepsis training. Nurses completed an electronic learning module as part of the induction programme which included sepsis, whereas the medical staff completed a taught session as part of their induction prior to commencing work within the emergency department (ED). Training compliance identified junior doctors were the only group of staff who were not compliant with sepsis training, with only 50% having completed this against a target of 90%.

The mandatory training programme was not comprehensive and did not meet the needs of all patients and staff. Not all clinical staff completed training on recognising and responding to patients with mental ill health, learning disabilities, autism and dementia as this was not considered as mandatory for staff to complete. Staff compliance with training for meeting the needs of patients with mental ill health, learning disabilities, autism and dementia was low. Seven staff members had completed understanding dementia, 34 staff had completed dementia level 2 training and 16 staff had completed a module entitled ‘dementia: positive approach to care’. This was out of a possible 335 staff members working in the department.

There were 5 modules of training for staff to complete around mental health. However, rates of staff completion were low. For example, the highest compliance recorded was 23 for the electronic learning module for mental health out of a possible 335 staff members who worked in the department. There was a mental health awareness for managers module in place for managers to complete, however, only 1 manager was recorded as completing this. The information did not identify out of how many managers this was.

It was acknowledged by the leadership team that compliance with Accessible Information Standard training and Oliver McGowan training compliance were low as these areas of training were not mandatory. There was a plan in place to increase this compliance by adding these on to a separate training module; 'vulnerabilities awareness'. However, as the compliance with the 'vulnerabilities awareness' day training event was at 7% during our inspection, we were not assured this would increase the compliance as expected. Oliver McGowan training which includes training in relation to learning disabilities and autism became a legal requirement for healthcare staff in July 2022.

Managers did not effectively improve mandatory training compliance. Managers told us they monitored compliance for mandatory training and prompted staff when training was due to expire, we were not assured the processes in place to support this were working given the poor compliance rates. An action plan failed to identify the poor compliance with training in mental health, learning disabilities, autism and dementia.

Safeguarding

Not all staff had completed safeguarding training to the level required; however, this improved over the course of the inspection period. Not all staff submitted safeguarding referrals in line with trust policy. However, staff told us they understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff were required to undertake training specific for their role on how to recognise and report abuse. Information showed overall, 83% of all staff had received training in safeguarding adults and children level 2, 82% had received safeguarding training adults level 3, and 65% of staff who were required to undertake safeguarding training children at level 3 had received it. The trust target was 90%. Only 20% of junior doctors had completed level 3 safeguarding training.

We raised our concerns about training compliance with the trust through a Letter of Concern. In response, training compliance slightly improved to 66% for staff required to undertake safeguarding children at level 3.

In June 2023 the CQC placed conditions on the trust's certificate of registration in relation to the safeguarding concerns. In response the trust improved safeguarding training compliance. Updated data showed 94% of nursing staff, 79% of medical staff and 89% of other staff working in the ED at Birmingham Heartlands Hospital had completed level 3 safeguarding children training. A further update provided by the trust showed the overall compliance for safeguarding was recorded as 91% in August 2023.

The trust submitted an action plan which identified there was a plan to continue to increase the training provisions to staff, as well as supporting this with '7-minute briefings' in relation to key safeguarding topics. There was a training matrix submitted which detailed dates and times for when training would be provided.

PREVENT training which focuses on safeguarding vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves was mandatory for all staff. Information provided identified 88% of all urgent care staff had received this training.

Despite compliance with training being variable, staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Not all staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. However, staff who were confident with safeguarding told us they knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us if they had concerns, they would either raise these with the senior nurse or would complete a safeguarding referral.

Data received in relation to a serious incident at this ED, prior to the inspection showed there had been ongoing missed safeguarding referrals for paediatric patients since September 2021, we therefore had concerns that not all staff were confident and competent in escalating safeguarding concerns. Despite action plans being put in place to address this, actions had not driven sufficient improvement to ensure all patients were safeguarded from abuse and harm if required. This finding was across all EDs within the trust, and we therefore took enforcement action against the trust to ensure urgent action would be taken to improve the serious concerns identified.

The trust had started a 'safety netting' process to identify 'missed referrals' for example where ED staff should have made a referral to the local authority about a specific patient but did not. Whilst the 'safety netting' checks identified missed referrals; and enabled a delayed referral to be made to the local authority; it did not drive improvement in terms of ensuring all staff were making timely referrals in line with national guidance and legislation.

There were 28 missed safeguarding referrals from October to December 2022 for vulnerable adults. From January to March 2023, this reduced slightly to 25 missed referrals. The same report identified there were 27 missed safeguarding referrals from October to December 2022 for paediatric patients; and 14 from January to March 2023.

Further information was shared with CQC in response to the conditions which were placed on the trust's registration in June 2023. The information identified there were 13 missed safeguarding referrals for children in May 2023. Eight of these referrals were in relation to children aged between 0 and 15 years, and 5 referrals were missed for children aged 16 to 17 years of age. This demonstrated there was ongoing risk to children who required action to be taken to keep them safe.

Staff followed safe procedures for children visiting the department. The trust had an abduction policy in place however, this was not routinely applied or tested within the ED, staff opted to follow the missing patient policy. Since our April 2023 inspection, the trust had enhanced their missing patient procedure to ensure actions were taken to contact the appropriate organisations if the patient was a child. Communication was sent out to all staff within EDs to ensure they were aware of what actions to take in the event of a missing child.

The service had recently improved their processes for following up on children who left the department without being seen. Staff told us this rarely happened, however, if this did occur, children would be followed up and their parents or guardians requested to bring them back if clinical information identified any concerns.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They mainly kept equipment and the premises visibly clean.

Prior to our inspection, the service had not performed well for cleanliness. The service had undergone an IPC assurance audit shortly before our April 2023 inspection. The audit did not give an overall compliance rating, however, the feedback provided to the ED leadership team indicated many areas which were found to be unclean, cluttered, and

therefore, a risk to patients. The audit for example, identified the commodes which were regularly used were dirty, dust and debris was found in all areas and work surfaces were in a poor state of repair which made cleaning difficult. Despite requesting for action plans to be submitted alongside any audits, we did not receive an action plan in relation to this assurance audit. However, during our last inspection we saw most areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The environment was mostly visibly clean. However, we saw the department was old and therefore, there were some areas which presented a risk to IPC. For example, we saw a consulting room used to triage ambulatory patients had a cracked floor. This meant this part of the floor would not be able to be cleaned to standards required to minimise infection risks.

The department had regular staff completing cleaning of the area and all documentation was observed to be up to date during inspection.

Staff mostly cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed items of equipment which had 'I am clean' stickers attached to them once they had been cleaned. However, we did find some examples where cleaning had not yet been done. For example, we observed a trolley in the corridor of the 'minors' area in the main ED building had a dressing with blood on it, and splatters of blood were on the trolley.

Most staff had completed their IPC mandatory training. However, junior doctors were below the trust target of 90% for this training with 81.3% compliance.

Staff improved when following infection control principles including the use of personal protective equipment (PPE). During our April 2023 inspection, we observed staff to have poor compliance to IPC procedures, such as not wearing PPE correctly, and not handwashing visibly soiled hands in between patient contact. However, during our July 2023 inspection, we observed an improvement. Staff adhered to the World Health Organisations (WHO) 5 moments for hand hygiene and were observed to be 'bare below the elbow' to enable effective handwashing. Staff wore PPE correctly and disposed of this in between patients. We observed staff using hand gel or washing their hands appropriately in between patients.

We observed a staff member correctly adhering to aseptic non-touch technique when treating and dressing an open wound. Following the patient's departure, the staff member removed the disposable couch cover and cleaned the immediate area to reduce the risk of cross contamination.

All areas had disposable privacy curtains. All had been replaced within the last 3 months except for those within the 'minors' area in the adjacent building to the main ED. These had not been changed since November 2022. Hospital privacy curtains can be easily contaminated with microorganisms therefore, it is important to ensure these are changed in line with trust policy to prevent hospital acquired infections.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment followed national guidance. At the time of the inspection, the clinical decisions unit had been changed into 'Majors C' which was used for patients who were unwell but stable and awaiting either admission to the hospital or further tests.

Urgent and emergency services

Managers had re-structured the ED space to support patient flow, particularly for patients attending by ambulance. Ambulances pre-alerted the ED when necessary, for example when bringing a very unwell patient, which meant clinical teams were ready to receive and work on these patients immediately. We saw this happen within the paediatric ED whereby the patient received timely clinical interventions.

The ED resuscitation area and high dependency cubicles were based nearest the ambulance entrance meaning very unwell patients could be brought straight to these areas. A hospital ambulance liaison officer (HALO) employed by the local ambulance trust, and a senior nurse from UHB, were situated in this area to coordinate incoming ambulances to appropriately stream patients to the best pathway.

Managers had created an ambulance decisions area which was staffed by senior paramedics and emergency care assistants from the local ambulance trust. Patients who could be seen by this team were directed here to be seen more quickly.

Managers at the service had re-purposed an open area of ED into a 2 bedded escalation area for when patient capacity outstripped the available bed space. This area had space to accommodate emergency equipment, although it did not have piped oxygen. Patients based here used portable oxygen if this was required. Patients had access to an emergency alarm. A nurse was allocated to this area at all times when patients were present. The purpose of this was to reduce 'corridor care' where patients were previously located on corridors, often with no dedicated nursing support.

The service had 2 'minors' areas where staff treated patients presenting with minor injuries, such as simple fractures. One of these areas was based within the main ED. The other acted as a 24/7 overflow area and was situated in the adjacent building which had previously been outpatients. The only other service using this part of the adjacent building at the time of the inspection was the GP led service where patients attending ED could also be streamed to between 8am and 10pm. Due to outpatients being moved to a new building, there were not many staff present. Patients or the public could freely enter this building at any time of day without staff being aware, particularly outside of the GP service opening hours. This area had no dedicated security and presented a risk to the staff working within this environment, particularly overnight. Whilst push button alarms were present, these only sounded in the immediate area so would not summon help from elsewhere across the site. To manage this, the staff working in this building often relocated over to the main ED building to see patients overnight where possible; and requested that patients who were known to be aggressive be seen in the main building only.

All waiting areas within the main ED were uncluttered and free from trip hazards. In the 'minors' area located in the adjacent building; there was a cage with empty boxes in one area of the waiting room. Other than that, the room was mostly clutter free. However, there were 2 doors within this waiting room. One door was locked preventing unauthorised access. The other door led into an old store cupboard which was not locked. This contained a box of face masks, broken furnishings and pieces of equipment (a floor cleaner and shelf from wall was on the floor, plus a shower chair and other bits of rubbish). There were also 3 sets of coat hooks which could present a ligature risk. This waiting room was not supervised by staff although we saw there was a call bell on the wall in the waiting room.

The paediatric department had their own entrance and required staff to allow those attending to access the department. This prevented unauthorised access to the department.

The ED had a room which was designated for patients who were experiencing mental ill health. The room met the Psychiatric Liaison Accreditation Network standards, as there were doors which opened both ways, cameras which monitored staff and patient safety, minimal furnishings and staff carried personal safety alarms.

Not all patients could reach call bells, however, when patients used their call bells staff responded quickly. All areas in the ED had call bells for patients to use. We observed some call bells in Majors C area where patients were unable to reach their bells and therefore, would not be able to obtain staff assistance if required.

Staff mostly carried out daily safety checks of specialist equipment. We sampled a selection of equipment in the department and found they were serviced, cleaned and regularly checked. We checked the resuscitation trolley in the 'minors' area in the building adjacent to the main ED. Staff had not always checked this daily. We saw April, May (with the exception of one check) and July 2023 (to the date of the inspection) daily checks were complete. However, 7 days were not checked in June. All consumables were checked. A hypo box for patients experiencing anaphylactic shock, and a paediatric emergency kit were present and in date.

The site resus team regularly attended ED to review resuscitation trolleys. They were in the process of creating resus packs which contained all equipment for a specific medical emergency in one package. These were clearly labelled with equipment expiry dates marked. These enabled staff to pick up the appropriate pack quickly as needed. The resus team were planning to roll out training for staff on using these packs.

The service had suitable facilities to meet the needs of patients' families. There were rooms which were away from the main areas and were used to deliver bad news in a confidential and dignified manner. The service also had a cold cot which was used in the event of a baby death, which meant the family were able to spend time with them.

The service had enough suitable equipment to help them to safely care for patients. We checked a range of consumable equipment across all areas of ED and found all items were safely packaged and in date.

Staff disposed of clinical waste safely. We observed staff correctly segregating clinical and domestic waste. Waste bins were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line. The management and disposal of sharps and waste was completed in accordance with legislation and local policy.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff mostly identified and quickly acted upon patients at risk of deterioration. However, not all patients were treated for sepsis in line with national guidance.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, not all patients were treated for sepsis in line with national guidance. The service used National Early Warning Scores 2 (NEWS2) to monitor adults, and Paediatric Early Warning Scores (PEWS) to monitor children, to identify the potential risk for deterioration. Staff we spoke with understood NEWS2, which was recorded electronically. They were aware of the triggers and alerts which were automatically created if a patient was identified as deteriorating; and aware of who to escalate concerns to, such as a more senior nurse or medical member of staff. We reviewed 15 sets of notes and found observations had been completed and a NEWS2 or PEWS completed for each set of observations. Where patients were identified to have a higher NEWS2 or PEWS, we saw evidence of escalation to the appropriate clinician for further review and further observations were completed.

We reviewed 2 sets of notes where sepsis was identified as the presenting complaint. There were areas for improvement noted with both patients. Both patients had a history of chronic lung conditions which meant the oxygen therapy being provided was not in line with the sepsis recommendations but was in line with treatment considerations for their

chronic lung conditions. One patient did not receive intravenous antibiotics, oral antibiotics were opted for instead and the second patient did not receive intravenous fluids as per sepsis guidance. We requested sepsis audit data following our inspection, the trust stated their sepsis data was now captured on their dashboard; however, this was not shared with CQC.

During our inspection, we saw navigator nurses and triage nurses appropriately directed patients based on clinical presentation.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. The department used a recognised triage tool to assess patients who arrived at the ED. This helped to prioritise care and treatment.

Staff knew about and dealt with any specific risk issues. Patients who were at a high risk of falls were placed in visible cubicles. Registered nurses used their professional judgment to assess if patients were safe on trolleys and if a nurse had any concerns, they could make any reasonable adjustments.

Senior staff told us one of the incident themes within the department was patients attending with pressure damage. Due to the increase in stay for patients who attended the department, it was important staff considered pressure damage and assessed patients who were at risk.

The number of ambulances waiting to bring patients into the ED had reduced since our previous inspection. Appropriate patients were directed to an Ambulance Decision Area (ADA) which was managed by paramedics and emergency care practitioners. Where patients were still kept on ambulances waiting to come into the ED, there was a process in place to ensure patients were reviewed and any deterioration escalated to staff in the department who would prioritise them.

The service had 24-hour access to mental health liaison and specialist mental health support if there were concerns about a patient's mental health. The service had access to a psychiatry liaison service for patients who were identified as requiring mental health support. Staff told us the psychiatry liaison service were responsive to referrals and available 24 hours, 7 days a week.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. There was a 'therapeutic and observation engagement' document in place that assessed individual risks to patients who presented with symptoms of mental ill health.

The service used security staff employed through a third-party company. These were based 24/7 in the main ED area. However, the 'minors' area located within the adjacent building did not have dedicated security to support staff if patients became aggressive or violent. Staff had to telephone for security which meant there would be a delay in receiving assistance if required.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. Handovers ensured safe continuity of information between shift changes and improved communication with patients and families.

Urgent and emergency services

Nurse staffing

The service did not have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, bank and agency staff were used to over staffing shortfalls where possible. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing and support staff to keep patients safe. Information received after the inspection identified there was a vacancy rate of 47.99 whole time equivalent (WTE) band 5 staff within the ED. The information identified there were 12 new WTE staff members due to start in the next 6 weeks, however, the department at the time of our visit was significantly understaffed for qualified staff.

Within the funded posts for band 5 staff (80.75 WTE) there were 7 WTE band 4 nurse associates. At the time of our inspection this meant there was a total of 32.76 staff members out of 80.75 in post.The trust had intended to mitigate the risks of this by over recruiting to band 6 and 7 posts, however, at the time of the inspection, there was only a small number of band 7 staff members who had been over recruited. Band 6 staff levels were just under the funded posts.

The ED had slightly over recruited staff within band 3 posts to support the team and band 2 staff were just under the funded posts.

The trust had a corporate team who were involved in the recruitment processes and there were constant recruitment programmes in place. However, the vacancy gap within the department was an area of concern for many staff.

Due to the significant staff shortages, the service relied upon bank and agency staff to provide safe staffing levels within the department. Managers made sure all bank and agency staff had a full induction and understood the service. Information provided by the trust showed in April 2023 there were more registered staff shifts filled with agency and bank staff (61% of filled registered staff shifts) than there were by substantive staff (29% of filled registered staff shifts) in the adult ED. There was also a requirement for non-registered staff to complete shifts in the ED. In April 2023, 22% of the non-registered shifts were filled with bank staff. Despite the need for bank and agency staff to enhance the staffing levels, in April 2023, 10% of registered shifts and 29% of unregistered shifts were not filled, meaning the ED may have been running on unsafe staffing levels on some days.

The ‘minors’ service in the building adjacent to the main ED was staffed by emergency nurse practitioners who worked independently. They had access to consultants where necessary to provide additional advice and support; although as the consultants were not based within the same building this could present a delay. During our inspection there were 4 emergency nurse practitioners and a student nurse which presented as sufficient for the number of patients seen.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers calculated the staffing requirements based on the guidance from the Royal College of Emergency Medicine. The division completed a workforce review every 6 months.

The ED manager tried to adjust staffing levels daily according to the needs of patients. We observed occasions in June 2023 where the ED had an uplift of staff for some shifts to meet additional needs of the service.

The number of nurses and healthcare assistants did not match the planned numbers. We reviewed staffing rotas for June 2023 and found there was not 1 day where the planned staffing for both registered staff and non-registered staff matched the actual staff on duty. There were 4 days where the actual staffing for registered staff met or exceeded the

planned staffing. However, on 9, 28 and 30 June 2023, there were significant shortages in the number of actual registered staff on duty (7 gaps on 9 June, and 5 on both 28 and 30 June). Despite the staffing figures showing the ED was either at funded or over funded positions for non-registered staff, there were shortages in the number of staff each day and on most shifts. The late twilight shift was a shift which was rarely staffed by the non-registered staff despite 4 staff being planned for this shift.

The service had high vacancy rates. The information shared by the trust indicated each ED was running on over a 30% staffing vacancy.

Information for turnover rates was only provided at divisional level. The information showed the division had a slightly higher turnover rate than the trust average. The division recorded 14.1% turnover rate compared to the trust average of 11.9%. Nursing staff saw the highest number of staff leave the trust in the last 12 months (52 staff). Due to the higher than trust average turnover rates, the staff were given the opportunity to attend exit interviews to identify what the division could do differently to retain staff.

The service had a sickness rate of 4.24% for the last 12 months. This was just over the trust key performance indicator of 4%. Information provided identified influenza had been a main source of sickness absence within staff in the department.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers used locum medical staff to cover shortfalls. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service relied upon locum medical staff to keep patients safe. The consultant workforce at the trust included 48 consultants, 25 of which worked across both EDs at Birmingham Heartlands Hospital and Good Hope Hospital. At the time of the inspection the arrangements were 1 consultant presence from 8am to 10.30pm. There was a senior decision maker (junior doctor in their fourth year of training and above overnight, until 8am). The consultants were on call overnight to come into the department if required.

Managers could access locums when they needed additional medical staff. Information shared after the inspection identified a high usage of locum staff. This was not restricted due to the need to enhance medical staffing to ensure patients were kept safe. In April 2023, 52% of all shifts were covered by locum doctors at Birmingham Heartlands Hospital.

Managers mostly made sure locums had a full induction to the service before they started work. Staff told us they had mostly had an induction when they started work in the ED. However, this was of variable quality and not all staff felt prepared to work in the department.

The service had recently undergone a recruitment campaign in May 2023 and was participating in the international trainee fellowship programme initiative to help improve staffing. The trust was recruiting 8 consultants from the cohort who were due to finish training imminently.

The medical staff did not always match the planned number. Information received after the inspection showed 14% of doctors' shifts did not have the required minimum doctor staffing levels.

Urgent and emergency services

The paediatric ED did not always have a dedicated paediatric emergency medicine consultant. This was not in line with 'Facing the Future - standards for children and young people in emergency care settings' (2018). However, staff could access a consultant from the paediatric medical service.

Sickness rates for medical staff were below the trust key performance indicator. All levels of medical staff had lower than 4% sickness rates for the last 12 months. Middle grade doctors had the highest level of sickness rates at 3.63% and consultants had recorded no sickness over the last 12 months.

The service did not always have a good skill mix of medical staff on each shift. Due to the gaps in staffing identified, we were not assured that all shifts had the correct skill mix.

The service always had a consultant on call during evenings and weekends. The on-call consultant was permitted to be 10 miles away from the hospital. If they lived further away than this, the policy stated the consultant would need to remain on site.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and staff could access them easily. The majority of patient records were electronic. The few paper records were clear, adequately detailed and legible.

We reviewed 15 sets of records and found they were easy to access, and the information contained enough detail. The records we reviewed at the time all appeared to have been recorded by the person responsible for reviewing and delivering care. However, we were aware of an issue identified by the trust where consultants did not always document their own reviews.

We reviewed 6 sets of 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms known at the trust as Recommended Summary Plan for Emergency Care and Treatment / Treatment Escalation and Limitation (ReSPECT/ TEAL) plans. All 6 records recorded what specific interventions were not to be undertaken; and where appropriate in what circumstances cardiopulmonary resuscitation could be carried out. All but 1 record specified clinical diagnoses and personal beliefs of the patients which supported the agreed decision. We saw, where appropriate, a consultation with the patient or family had been undertaken prior to making decisions not to resuscitate.

When patients transferred to a new team, there were no delays in staff accessing their records. Most areas within the hospital worked on the electronic system, this meant when a patient was transferred between teams or out to a ward, staff had immediate access to the patient records. Staff told us there were adequate amounts of computers to enable them to access records for patients when they needed to.

Records were stored securely. Computers were password protected and easily accessible for staff in the department. Paper notes were kept in cabinets at the nurses' station.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The trust had their own in-house electronic prescribing and medicines administration (EPMA) system. It provided information in one place including the patient's medical requirements, a medicine history and up to date information on prescribing. Where dose adjustments needed to be made for weight-based medicine prescribing, the system alerted the prescriber and calculated the correct dose.

Records of medicines administration including the route of administration and specific times of administration were completed on the medicine records reviewed. We saw an example where a medicine was 'paused,' based on blood test results, and the reason for pausing the medicine was clearly documented by the clinician on the EPMA system.

Information on missed doses of medicines was not available for the ED. However, a quality indicator was being designed so that this information would be available for monitoring.

Patients' allergies were routinely recorded on all medicine records seen. This meant that allergies were highlighted, and medicines could be prescribed safely.

Weights of patients were recorded on medicine administration records which is important for calculating weight-based medicines prescribing.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Whilst staff did review patients' medicines there was no clinical pharmacy team based within the ED to help to review patients' medicines on admission and provide additional medicine advice and prescribing support. There was however, a pharmacy technician who supported the ED with the safe handling and management of medicines. Although pharmacy services were not available 7 days a week, staff knew how to obtain medicines out of hours. We were informed that an extended pharmacy service was going to be introduced that would cover patients admitted from ED to the acute medical unit.

Staff did not always store medicines securely or manage medicines safely. The trust was working hard to improve overall medicine storage within the ED. However, medicines were not always managed safely or securely, mainly due to the poor storage arrangements. One medicine fridge was not locked or secure and temperatures were not always monitored daily. The latest Safe and Secure Handling of Medicine audit (October 2022) identified areas that needed improving. However, it was recognised that the current storage arrangements, although not ideal, were a temporary solution whilst a new purpose-built medicine storage room was being completed and anticipated by the end of May 2023. We re-visited this during our inspection in July 2023. The new cupboard was finished with the exception of the controlled drug storage and the improvements this would have on medicine storage was acknowledged. The cupboard had a link to the electronic system and was able to flag any drug interactions staff would need to be aware of. Staff had commenced using this for general medicines. Controlled drugs were due to be moved over in the days following our inspection.

Resuscitation medicines required in an emergency were stored in tamper-evident boxes which follows Resuscitation Council (UK) guidance. Staff recorded safety checks on emergency medicines and equipment to ensure they were safe to use if needed in an emergency. However, intravenous fluids stored on the resuscitation trolleys were not stored securely and the trust must ensure if required they were safe to use.

Controlled drugs (controlled drugs are medicines requiring more control due to their potential for abuse) were stored safely and securely with access restricted to authorised staff. Checks were undertaken and recorded by 2 staff twice a day. Checks of controlled drugs showed that they were within date and stock balances were accurate.

Medicines which were time sensitive for administration were stored within a dedicated drawer to ensure they were located easily and quickly when needed, for example medicines for Parkinson's disease and epilepsy.

Staff followed current national practice to check patients had the correct medicines. Staff undertook medicine history reviews and clinical checks on prescribing. This ensured patients' medicine records were up to date and accurate before they were admitted or moved between services.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trust had an electronic system for recording incidents and staff we spoke to were able to identify its use and how to access the system. Staff knew how to report incidents and gave us examples of what should be reported.

The trust had a Medicines Safety Officer (MSO) in line with NHSE directives. The MSO investigated concerns of safe medication practice, reviewed medication incident reports for local and national learning and investigated and led analysis of medicine incidents.

Decision making processes were not fully in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There was a 'Children, Young Person and Adult Restraint Procedure' (24 June 2022). However, there was no policy or guidance for the use of rapid tranquilisation which may be used where urgent sedation is needed for managing violence and aggression.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and mostly shared lessons learned with the whole team and the wider service. However, when things went wrong, staff did not always exercise the duty of candour.

Staff knew what incidents to report and how to report them. Without exception, all staff knew how to report incidents and were aware of what incidents and near misses they were required to report.

Staff raised concerns and reported incidents and near misses in line with trust policy. There were 883 incidents reported between April and June 2023. The majority of incidents were graded no harm (732 incidents) and low harm (121 incidents). There was 1 incident graded as moderate. The main theme of incidents was in relation to pressure ulcers (526 incidents), non-adherence to standards (49 incidents) with verbal aggression and aggressive behaviour reported as the second top theme (44 incidents) and patient absconding as the third most common incident (43 incidents).

There were no reported never events in the ED in the last 12 months. Managers shared learning from trust wide never events if there was appropriate learning from them.

Most staff reported serious incidents clearly and in line with trust policy. Information on the STEIS (Strategic Executive Information System) showed there were 3 serious incidents reported in relation to the ED between January and June 2023. Two of these incidents were reported retrospectively. However, the other incident occurred in January 2023. These incidents were categorised as a diagnostic incident, treatment delay and an obstetric incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Information received after the inspection showed division 3 which ED was part of had identified challenges when completing the formal duty of candour in relation to incidents. In minutes of a divisional

quality and safety group meeting, it was identified that the division was now achieving 70% compliance with duty of candour for stage 1 and 66% compliance with duty of candour at stage 2 for quarter 3. This was identified as an improvement from the previous quarter; however, this indicated that the division were not always exercising duty of candour in incidents where this was required.

We reviewed 3 examples where staff at the service undertook the duty of candour following an incident of moderate or above harm. The service followed their regulatory requirement when doing so; providing an explanation of what had gone wrong and actions to reduce the risk of the same incident occurring.

There was inconsistent feedback from staff in relation to feedback from investigation of incidents. Not all staff received feedback from incidents they had raised and they did not always receive feedback in relation to any lessons learnt from significant incidents. Staff were not aware of any recent serious incidents within their department and they were not able to recall the last serious incident which occurred. However, as above, information on the STEIS showed there were 3 serious incidents reported in relation to this ED between January and June 2023. Information received after the inspection showed there was feedback from significant incidents through a newsletter called 'Risky Business' as well as local education on learning from incidents.

Despite staff not having an awareness of any changes that were made as a result of incident feedback, information provided after the inspection identified some changes which had been made as a result of some significant incidents.

We reviewed a selection of root cause analysis reports, completed to investigate serious incidents. We found managers investigated incidents thoroughly and gave patients and their families an opportunity to be involved in the investigations.

Managers debriefed and supported staff after any serious incident. Some staff reported they had been involved in debriefs following significant or serious incidents.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment which was mostly based on national guidance and evidence-based practice. Managers mostly checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983. However, we were aware of some gaps in pathways and process which was impacting patient care and treatment and some out-of-date policies.

Staff mostly followed up-to-date policies incorporating national clinical guidance to plan and deliver high quality care. However, there were policies which were out of date. We saw that the department implemented most relevant clinical guidelines from the National Institute for Health and Care Excellence and other relevant professional bodies such as the Royal College of Emergency Medicine (RCEM). Information around policies, guidance and standard operating procedures was mainly found on the trust intranet which staff told us was accessible to them.

There were policies, procedures, and guidelines in place, such as those in relation to sepsis, safeguarding and infection control. Policies were version controlled and contained links to relevant guidance and legislation. However, some policies, such as the disciplinary procedure, employee relations policy and best interest policy, were not in date.

However, we were aware of concerns in relation to pathways at this ED which were not meeting relevant guidance due to delays in accessing specialist intervention. We were also aware of a recent Regulation 28, Prevention of Future Deaths report which had been issued by the coroner in relation to the care and treatment a patient received at the ED. The report highlighted concerns over the trust not following RCEM guidance published in 2016, in relation to patients who return to ED with unresolved signs and symptoms requiring escalation to a consultant.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff worked closely with the psychiatry liaison team. If the use of the Mental Health Act was required, psychiatric consultants would attend to support the ED staff.

At handover meetings and transfer of care handovers, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. This was an embedded practice that staff provided a complete and holistic handover of patient needs which included both psychological and emotional needs of patients.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. In our April 2023 visit to the ED, we raised our concerns with senior staff in relation to patients not receiving adequate nutrition and hydration whilst in the ED. In July 2023, we observed patients being provided with nutrition and hydration. Staff were aware of patients who were diabetic and ensured they were provided with adequate provision during their attendance. Staff aimed to meet the nutritional needs and choices for patients who required an alternative diet due to religious, cultural, or due to special dietary requirements.

Patients could access fresh drinking water, food and drinks from vending machines and during opening hours, the cafés in the main building.

We did not observe any nationally recognised screening tools used to monitor patients at risk of malnutrition during our inspection. However, staff told us specialist support from staff, such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff mostly assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. However, documentation of pain scores was not always completed in a timely manner.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used a pain scale of 0 to 10 when assessing pain, with 0 being no pain and 10 relating to severe pain. Alternative pain assessment methods were used for patients who were unable to communicate with staff. However, we observed some patients did not have their pain score documented in a timely manner.

Patients mostly received pain relief soon after it was identified they needed it, or they requested it. The last audit which the trust completed on pain management in December 2022 showed analgesia was given to all patients who indicated they were in pain.

Patient feedback about pain relief was varied. Two patients said they had been asked about their pain, including a paediatric patient, and pain relief had been offered as necessary. Two other patients told us they had not been asked about pain nor offered pain relief. One of these 2 patients stated they were in substantial pain due to their presenting condition; this was also visible through watching their body language when receiving treatment. However, this patient did also add they had been seen so quickly from arrival to treatment; they believed staff may not have had time to undertake pain assessments.

Staff prescribed, administered, and recorded pain relief accurately. We did not observe any concerns around the timeliness of administering medications to patients. Additional pain relief was prescribed for patients who may require this in addition to routine pain relief, and we saw where staff had provided this for patients.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements which would in turn improve patient outcomes.

The service participated in relevant national clinical audits. The department was signed up to participate in the RCEM audits. The most recent audits which the department participated in were 'Consultant Sign-Off', 'Infection Prevention and Control' and 'Pain in Children'. We requested details of outcomes after our inspection; however, the trust shared reports which did not indicate how the location performed within the audits.

Managers and staff carried out a programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards. However, where outcomes did not meet the required standard or expectation, the ED identified recommendations and implemented actions to learn and improve. In the NASH 3 audit (National Audit of Seizure Management in Hospitals- Round 3 audit, November 2020) this showed the department was performing not far outside of the national average for a lot of the standards, however, there were areas where it was identified there were missed opportunities to improve the management of patients' care and treatment.

Local audits were conducted in the ED for safeguarding, medicines, records, infection prevention and control/ cleanliness audits. The ED had a dashboard which provided real time compliance with a range of standards including NEWS2, sepsis and falls.

Sepsis performance data for June 2023 showed 92.6% patients received IV-antibiotics within 1 hour against a target of 100%. Seventy percent of patients had a blood culture obtained prior to starting their antibiotics against a trust target of 100%.

The trust told us the performance for obtaining blood cultures prior to giving IV-antibiotics had improved since 2022; and further work was ongoing to improve compliance within the EDs; performance for this measure was poor across all 3 EDs.

Leaders were due to review sepsis performance data at Clinical Dashboard Review Groups to develop communication for the wider staff group. However, these were on hold at the time of the inspection.

Information was shared after the inspection about a major trauma audit which was conducted, looking at major haemorrhage, tetanus exposure and tetanus immunoglobulin use. However, no results of this audit were shared, despite recommendations for improvements in practice disseminated to medical staff in the ED. The trust intended to repeat this audit to review any improvements.

Managers used information from the audits to improve care and treatment. Information showed medical staff from the division completed local audits on all sites. Results from some of these audits had led to publication in the RCEM learning resources and national presentations which was not only leading to improvements on a local level but nationally. In addition to this, the results of a local audit had led to the implementation of a Local Safety Standards for Invasive Procedures (LocSSIP) for chest drain insertion. LocSSIPs are safety checklists and standards to ensure interventional procedures are carried out with essential safety barriers in place and minimise risk to patients.

Improvement was checked and monitored. Most local audits were on a regular audit cycle which reviewed the actions identified from the previous audit to identify if improvements were made. Audit outcomes were discussed at divisional governance meetings, with the expectation for information to be disseminated to all staff in the department.

The service had a higher than trust average risk of re-attendance. The service recorded 4, 289 reattendances within 7 days of attendance between November 2022 and April 2023, out of 53,140 total attendances. This gave a reattendance rate of 8.1%, which was the highest out of the 3 trust EDs. The trust average for this period was 7.43% which was lower than the national reattendance rate of 10% for 2022.

Competent staff

The service made sure staff were competent for their roles and held supervision meetings with them to provide support and development. However, managers did not appraise staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were required to complete the trust's induction programme when starting.

Managers gave all new staff a full induction tailored to their role before they started work. Newly qualified nurses worked supernumerary to ensure they were confident and competent before working independently. Feedback was positive; managers promoted an individualised approach to the induction process which enabled staff to develop in line with their individual learning styles; therefore, supporting a more positive culture and retention.

Managers did not support nursing and support staff to develop through regular, constructive appraisal. Information shared with us after the inspection showed 54% nursing and support staff had received an appraisal. This was below the trust target of 90% and the division's aspiration of achieving the pre-pandemic rate of 88.1%. Staff who had undergone an appraisal told us they were supportive and meaningful.

Managers did not support medical staff to develop through regular, constructive clinical appraisal of their work. Information shared with us after the inspection showed 57.6% of medical staff had received an appraisal. Further information highlighted that the trust approach to non-trainee medical appraisal was in line with the General Medial Council requirements. However, the compliance level was below the trust's target of 90% and raised concerns over the trust's compliance with the General Medial Councils requirements.

Despite not all staff having received an appraisal, staff felt they had the opportunity to discuss training needs with their line manager and clinical educators and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training required for their role.

The clinical educators supported the learning and development needs of staff. Staff told us they could access training to support continued professional development. The clinical educators also supported newly registered staff in the department on their preceptorship package. The clinical educator who worked with the paediatric ED team was also involved in the work to improve staff awareness and knowledge with safeguarding following the concerns which we raised.

No formalised ED team meetings were held at the time of our inspection. However, managers made sure staff were aware of any important messages and learning from incidents or complaints. In addition to this, there were copies of 'Risky Business' available for staff to review.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We observed an emergency nurse practitioner (ENP) work with a student nurse to develop their competency in working with minor injuries. The approach taken by the ENPs was supportive, open and non-judgemental. The ENP took adequate time to explain the condition of the patient they were due to treat and to develop the student's knowledge of the specific assessment and treatment options before seeing the patient.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us staff from Human Resources were extremely supportive to all involved when areas of poor performance were identified.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff worked across health care disciplines and with other agencies when required to care for patients. A trust wide police liaison officer funded by the police force covering this area worked across site to provide support and teaching to staff including working with patients who demonstrated offending behaviour whilst on site such as hate crimes and violence. This was a new role being piloted at the trust and was not 24/7 at the time of the inspection. Feedback from ED staff was positive in terms of what the service offered staff. Where staff suspected injuries may be related to gang activity; they contacted the police who would follow this up with the patient if the patient consented.

Staff could access various liaison teams including the homelessness liaison team, alcohol liaison team, the psychiatric liaison team, the older persons assessment and liaison (OPAL), and an overseas patient's liaison team to support with patients who required extra support.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff attended joint meetings with the above teams to discuss patients and improve care.

Staff referred patients to the psychiatry liaison team for mental health assessments when they showed signs of mental ill health or depression or if clinical history indicated this was required.

Seven-day services

Not all key services were available 7 days a week to support timely patient care.

Some services were available for 24 hours a day, 7 days a week. The service had access to their own X-ray department 24 hours a day, 7 days a week, as well as access to laboratory support for blood tests. However, other diagnostic imaging services were not available out of hours, which was part of the concern in relation to pathways, such as the Cauda Equina pathway.

The ED had access to consultants 24 hours a day, 7 days a week with physical on-site attendance between 8am and 10pm, outside of these times, they were accessible via the on-call system (allowed to be 10 miles away maximum). Information was requested to demonstrate how the service was performing against the NHS England's 7-day service priority standards for the first consultant review. The information showed 92.8% of patients received a documented doctor's review (by any grade doctor) within 14 hours of attending the service. The service indicated when seeking out information for a true consultant review (for example, where the consultant had documented their review themselves) this fell to 47.5% of patients. It was also indicated by the service that this was likely to be higher, however, most consultant reviews were documented by a junior doctor. At the time of our inspection, the service was unable to demonstrate that they were meeting this standard.

The service did not have 24-hour 7 day a week access to the safeguarding team or OPAL team. These teams worked from Monday to Friday until 4pm, which meant the ED did not have support when raising a safeguarding or seeking support for older patients who met the criteria for assessment. The biggest concern relating to the safeguarding team was the lack of availability out of hours to be able to support the staff team within the children's or adult's ED.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on units. We saw various leaflets, signs and posters which promoted healthy lifestyles and effective recovery from presenting conditions. For example, we saw posters displayed explaining what home-based activities could impact negatively on plaster casts following a fracture.

We saw posters displayed explaining support available for those patients or visitors at risk of domestic violence and/ or female genital mutilation. However, these posters were from the NHS trust that Birmingham Heartlands Hospital was part of before merging with University Hospitals Birmingham NHS Foundation Trust in 2018. Therefore, we were not assured as to how up to date this information was.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us the training they received around mental capacity had enabled them to develop the knowledge and competence to identify when a patient may be lacking capacity and how to assess the patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available and clearly recorded consent in patients' records. We observed staff obtaining formal consent for treatment (when specific tests and investigations were required to be completed) and explaining all details thoroughly for patients to understand. We also observed staff gaining informal consent when taking patient observations.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. During our April 2023 inspection, we observed patients who were unable to consent for themselves following assessments of capacity to consent, and found staff were acting in their best interests. During our July 2023 inspection, we did not observe any patients who were unable to consent for themselves, however, staff were knowledgeable about the actions they would take in this situation.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Young people told us staff spoke directly to them to understand the presenting condition, rather than asking family or carers to speak on their behalf.

Staff mostly received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Information provided after the inspection showed 89.3% of staff in adults ED had completed their MCA training. This included nursing staff, support staff and medical staff. In addition to this 95.7% of ENPs and 90.5% of paediatric staff had completed their MCA training. The trust target was 90%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, MCA and the Children Acts 1989 and 2004 and they knew who to contact for advice. A member of the vulnerabilities team (within the trust's safeguarding team) was based in the ED. They worked with staff to ensure the least restrictive practice was undertaken and helped to educate ED staff. Staff also worked closely with the psychiatry liaison team (PLT) who provided any additional advice and guidance for staff in relation to providing best care for patients with mental ill health.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff told us the use of Deprivation of Liberty Safeguards was rare within the department, however, they were aware of the correct process to follow and the documentation to complete should a patient require this.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us if they had concerns about a patient, they would discuss with the lead nurse or the vulnerabilities team, who were now part of the larger safeguarding team.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. A monthly report was completed by the director of safeguarding in relation to vulnerable patients which included the completion of mental capacity assessments. The report identified not all patients would require an assessment to be completed, however, the report identified there were a number of patients where they were identified as vulnerable, no assessment was completed but no rationale was provided as to why this was not completed. It was noted that the data included in the report covered vulnerable patients who attended both the ED at Birmingham Heartlands Hospital and the ED at the Queen Elizabeth Hospital.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Urgent and emergency services

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. When 'walk in' patients arrived at the emergency department (ED) they booked in with receptionists at a desk with a glass screen based in the waiting room. Despite this, we observed conversations were mostly discreet and protected patients' privacy as much as possible given the environment.

We observed staff, including consultants, introduce themselves to patients with their name and role before talking about their condition.

Patients said staff treated them well and with kindness. All patients we spoke with told us staff had been kind and caring during their visit to ED. Patients told us they did not feel rushed and felt staff always had time to talk to them.

Staff mostly followed policy to keep patient care and treatment confidential. Staff mainly treated patient records and information confidentially. However, we observed a pile of paperwork which was left unattended in minors ED. We did not thoroughly review this paperwork, however, noted this was unattended and if patient details were stored within the paperwork, there could be unauthorised access to this information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff providing respect and compassionate care to patients who had attended due to mental ill health. There were times when staff found the circumstances challenging but ensured the care and treatment provided was always kind, dignified and non-judgemental.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Cultural and religious needs were well understood, and staff ensured any specific cultural needs would be considered whilst in the department. Staff also told us there was good access to various religious leaders to support patients of all faiths.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff being supportive and sensitive when discussing the findings of tests which had been completed which would have a significant impact on the patient. We also observed examples where staff discussed sensitive information with patients and their family and provided them the emotional support they required.

Staff supported patients who became distressed in an open environment and helped patients maintain their privacy and dignity. Where staff were aware of patients with neurodiversity including sensory processing aspects, staff tried to support patients to be as comfortable as possible. For example, enabling a patient to sit in a quieter waiting area.

We observed security and nurses within the entrance area and waiting area for ambulatory patients deal calmly and respectfully with a patient that demonstrated a strong emotional and behavioural response to being asked to leave for

the benefit of other patients' safety. This was a challenging situation during which security staff were assaulted. However, they remained professional and discreet when explaining why the patient was being asked to leave; and escorted the patient away from the area without the need for use of force or further intervention, such as from the police.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. A staff member who supported patients and their next of kin to retrieve lost or left property gave emotional support at potentially very distressing times, such as following the loss of a loved one at ED. They contacted the patient and/ or next of kin offering a range of communication options and times to speak with the person. They offered a range of ways people could collect property and if appropriate, worked with the next of kin to collect property, such as sentimental items during viewings of a deceased loved one. They understood the importance of sentimental items and went over and above to locate items for patients and next of kin, such as an item of jewellery which contained the ashes of a couple's son which was misplaced during a visit to ED. Often patients or next of kin were distressed upon realising items were missing; staff kept regular contact with the family until the items were located and reunited with their owners.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed some positive examples of discussions with patients around their care and treatment. We observed staff take time to explain patients' conditions prior to discharge; clearly explaining how to safely care for themselves after they left the hospital.

Patients told us they felt staff listened to them and understood their views.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff communicating with a range of patients, each time personalising communications to the individual . One example was a member of staff communicating with a child, this was conducted in a way which held the child's attention enabling the member of staff to complete a full and meaningful assessment. Within the feedback shared with us by the department, many patients had indicated staff had communicated with them on a level they understood.

Patients and their families could give feedback on the service and their treatment, and staff supported them to do this. The service collated feedback through the Friends and Family Test (FFT), as well as through their own feedback system. The FFT results for February 2023 showed 75% of patients who responded had a positive experience within the ED. The results for the ED had improved since July 2022, when 58% of responses indicated a positive experience. The trust had started a task and finish group which looked to address some of the feedback received.

Staff supported patients to make advanced and informed decisions about their care. Our observations and feedback provided by patients supported this.

The feedback from the ED survey test was positive. The results for 2022 were imminently due, however, results from 2020 showed the trust mainly fell into the 'about the same' as most other trust categories for the questions asked. They had performed worse in 1 aspect than most other trusts and this was in relation to a question which asked patients if the care and support they expected after leaving the ED was available when they needed it. There was no additional information in relation to why patients had responded negatively to this, and more importantly what services were not

available. There were 5 areas where the trust performed better than in the previous survey. This included how long patients waited with the ambulance crew (if taken to ED by ambulance), how long they waited before a nurse or doctor spoke with them, how long patients waited for an examination by a nurse or doctor, how clean the department was and overall if they had a good experience.

Is the service responsive?

Requires Improvement 

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers tried to plan and organise services, so they met the needs of the local population. At the time of the inspection, the service saw more patients than it was designed for in terms of both the physical environment and staffing numbers. This meant patients had long waits.

To mitigate this, managers had worked with the wider system to create streaming pathways so that patients were seen as safely and quickly as possible.

Managers had created navigator posts which were band 6 nurses (more experienced nurses) who received specific training to quickly assess and signpost patients to the most appropriate areas. They worked within the emergency decisions area alongside triage nurses.

Patients who arrived by themselves rather than on an ambulance were assessed and then directed to the most appropriate place of clinical care. For patients who were acutely unwell such as exhibiting serious cardiac symptoms; they were directed to the 'majors' area where they received close monitoring, care and treatment. Patients with minor injuries were directed to the minor injuries unit which was open 24/7. This was in part located within the ED building; and additional capacity had been created in the neighbouring building.

Facilities and premises were appropriate for the services being delivered. The ambulatory entrance to the adults ED was only accessible to patients by stairs or a long ramp. One patient we spoke with who, due to their presenting complaint, had reduced mobility told us they needed the ramp but chose to use the stairs due to these being quicker however, this impacted negatively on their pain levels.

Patients and people accompanying them had access to toilet facilities including disabled facilities and baby change areas.

Patients told us general parking at the site was good, however, often disabled parking bays were taken by cars which did not display a blue badge. Patients told us this meant that they had to travel further from their car to where they needed to be despite having a blue badge themselves.

Patients and their families had access to free telephones to call for taxis on discharge. Numbers for local taxi firms were displayed.

Some waiting areas had televisions; however, not all were used. In the paediatric ED waiting area, age-appropriate films and shows were displayed. However, in the emergency decisions area waiting room, the television was neither on nor in a place particularly convenient for patients to be able to see the screen.

The ED had a viewing room and bereavement room for people who had lost a loved one at ED to sit quietly; and also, to view the body when appropriate. These rooms were decorated in a way which was sensitive to their use; and were kept clean and tidy. Staff had access to knitted pairs of hearts in this area which could be given to family members who had lost a loved one in ED. One heart would stay with the deceased patient, and one would go with the family.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff were extremely complimentary about the support they received from the psychiatry liaison team (PLT). The PLT were able to provide assessment, advice and treatment for patients who were over the age of 16 years. For patients under the age of 16 years, the service had good links with another service within the region who were responsive at all times of the day.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had systems which alerted staff when patients required additional support. This included but was not limited to; patients with learning disabilities, patients known to be aggressive or violent, patients who regularly attended and patients who were a known safeguarding risk.

The service tried to relieve pressure on other departments when they could treat patients in a day. For patients who did not require emergency care but could be seen by a GP, a service was based in the same area as minors in the building adjacent to ED. The GP led service ran from 8am to 10pm, and 2 GPs offered 186 slots a day. If patients who required a GP rather than emergency care arrived at ED outside of the GP led service's opening hours, the ED receptionist could make an appointment for the following day. Patients could then either wait for that appointment or go home and return.

Meeting people's individual needs.

The service took account of patients' individual needs and preferences. However, staff did not always make reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental ill health, learning disabilities and dementia received the necessary care to meet all their needs. Staff made sure patients who required additional support received this through alerting specialist teams of their attendance or welcoming their family, friends, and carers to attend the department with them. The service had access to an alcohol care team for patients who required support due to problems with alcohol. There was also specialist support for patients who were homeless and who required care and treatment.

The department was not designed to meet the needs of patients living with dementia. Although the decoration of the department was plain and not overwhelming to a patient's sensory functions, signage was not consistent with recommended dementia friendly standards.

Staff were encouraged to support patients living with dementia and learning disabilities by using documents and patient passports. However, staff did not always complete the 'This is me' document. Staff were encouraged to ensure 'This is me' and hospitals passports were updated and used for patients who these were applicable to. The director of

safeguarding completed a monthly compliance report in relation to patients who were vulnerable and attended the ED at Birmingham Heartlands Hospital and Queen Elizabeth Hospital Birmingham. An element of this report looked at the use of passports and other specialist documentation. The report for April 2023 looked at activity for January to March 2023. It showed staff were improving with using specialist documentation, however, the 'This is me' document continued to be the document which was not regularly completed. This meant patients who this would be useful for were at risk of having a more negative experience due to staff not understanding their individual needs.

Not all staff understood how to meet the information and communication needs of patients with a disability or sensory loss. There was no trust policy around this.

The service did not comply with the Accessible Information Standard, despite this being a legal requirement for healthcare providers since 2016. An individual member of staff was working on a quality improvement project to improve accessible information for patients with disabilities which affected communication. This project also included supporting patients who did not speak English with basic care needs. However, if this staff member was not driving this initiative at this service; we would not be assured the trust would be working towards embedding the Accessible Information Standard to meet legal requirements.

The department had invested in some staff to learn the alphabet for British Sign Language (BSL). This enabled staff to finger spell basic words to aid communication with patients who used BSL as a first language. There were also staff who had completed Makaton training to enable them to communicate with adults and children with learning or communication difficulties (Makaton is a language programme that combines signs, symbols and speech to give different options for people with learning or communication difficulties to communicate. It is not a language in its own right). Staff who had completed Makaton told us they were often called upon to communicate with patients who were non-verbal or who had a learning disability. Makaton trained staff were also used to communicate with patients who used BSL despite BSL being a recognised language whereby an interpreter should be provided as per the trust policy.

The service did not have information leaflets available in languages spoken by the patients and local community. However, Managers told us staff and patients could get help from interpreters including BSL interpreters when needed. Senior staff told us there were many staff within the ED who were able to speak other languages fluently. There had been occasions when patients had attended the department with their own interpreters as well. Outside of these options, the ED had access to a telephone-based interpretation service for interpretation of spoken languages.

A family communication project being trialled in ED worked to support patients and families to access interpreters where required; and supported patients with cognitive impairment, learning disability and mental ill health to communicate with clinical staff.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff were able to offer patients appropriate food choices to meet their cultural and religious needs through a special order to the catering department. Patients could use vending machines and water coolers if they required any additional provisions.

The paediatric ED had access to a play specialist who would support the children through therapeutic play. Unfortunately, these staff were not able to provide a 7-day service. However, they ensured the ED had the correct provisions in place to meet the needs of paediatric patients. There were age relevant toys available for children and electronic devices for the older children to use whilst waiting in the ED. There was also a television in the department which was playing age-appropriate shows.

Urgent and emergency services

Access and flow.

People could access the service when they needed it and received the right care promptly. However, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The trust monitored the handover delays from ambulance to ED. Between 27 March and 26 April 2023 there were 3,311 patients who arrived at the ED by ambulance. Of these, 611 patients (18.4% of ambulance attendances) recorded a delayed ambulance handover of over 30 minutes. Of these, 306 patients (9.2%) were recorded between 30 and 60 minutes delayed. Although the ambulance delays had improved since the previous inspection in June 2021, the ED was still challenged from a flow and capacity perspective. Since our previous inspection, an ambulance decision area (ADA) had opened in September 2022 in each of the EDs. The ADAs were overseen by ambulance staff. This helped reduce the number of ambulance delays impacting on the ability for the ambulance trust to respond to further emergencies. The ADA at Birmingham Heartlands Hospital consisted of 7 trolleys and 2 chairs and was managed by 2 paramedics and 2 ambulance care assistants. Between November 2022 and March 2023, there were 3,771 patients who were admitted into the ADA, which worked out between 22 and 30 patients per day. Information received from the trust showed on average patients spent 6.3 hours in the ADA before they were either admitted or discharged.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had 2 'same day emergency care' (SDEC) pathways in place. Under this care model, patients presenting at hospital with relevant conditions could be rapidly assessed, diagnosed, and treated without being admitted to a ward, and if clinically safe to do so, could go home the same day their care was provided. One of these was specific to the older persons assessment and liaison (OPAL) service and the other was for the medical assessment unit. These were in place to support patient flow throughout the department.

The minor injuries unit based at Solihull Hospital had very recently re-opened following its closure during the pandemic. Staff told us they had already seen an impact in terms of reduced numbers of patients coming to Birmingham Heartlands Hospital ED for minor injuries.

Leaders audited triage performance, identified causes for poor performance and developed action plans. RCEM state triage should occur within 15 minutes of arrival or registration and should normally require less than 5 minutes contact. Performance figures for April to June 2023 showed on average, adults attending ED waited over 15 minutes to be triaged. Staff triaged paediatric patients within the 15-minute target.

In April 2023, the average time adults waited to be triaged was 40 minutes. In May 2023, the average time was 55 minutes. In June 2023 the average time was 61 minutes. The largest delays were seen for patients attending Majors (for more serious illnesses and injuries). For example, in April 2023, the wait to be triaged for majors was 73 minutes. Adults attending other areas of ED waited 33 minutes or less by comparison.

In April, the average time children waited to be triaged was 10 minutes. In May the average time was 13 minutes. In June the average time was 13 minutes.

The service performed worse than the trust overall ED triage waiting times (the average triage wait times for all 3 EDs).

The matron reviewed the triage data monthly and had conducted a deep dive to identify root causes. The following causes were identified:

- Due to overcrowding within ED, plus patients who were due to be admitted to a ward being held in ED as there were no spaces on wards, triage nurses provided on going care for patients as well as completing triage slots. This meant there was less time and staff available to triage patients.
- Emergency nurse practitioners (ENPs) were seeing patients directly without triage, resulting in a perceived increased triage time.
- Some staff were reverting back to a more detailed triage, resulting in a delay.
- Not all staff were adhering to triage escalation processes.
- External agency staff were not always compliant with the trust procedure.

As a result of these findings, the matron had developed an action plan to address the triage waiting times. This included:

- Local leaders provided education and training around triage priorities and processes to all staff in handovers and throughout shifts.
- Leaders reiterated the triage escalation process.
- The trust was conducting on-going recruitment to reduce external agency within the department.
- Local leaders provided education to the ENPs team regarding triage category.

Patients we spoke with who were in the paediatric ED and 'minors' told us they had been seen quickly for both initial assessments and ongoing care and treatment. All told us they were satisfied with the time they had waited and did not feel this was excessive.

The number of patients leaving the service before being seen for treatments was low. The service routinely monitored this data. This showed the location had a relatively low number of patients leaving the service before being seen, with only approximately 3.06% of patients leaving the service before being seen in April 2023. This was lower than the trust average which was 3.24%.

Managers and staff tried to make sure patients did not stay longer than they needed to. However, information showed in February 2023 on average patients waited in the ED for an average of 231 minutes, which was higher than the England average of 68 minutes. This information was recorded as an average for the trust and therefore, it was not possible to identify if Birmingham Heartlands Hospital was performing better or worse than the 2 other trust EDs. Further information received from the trust identified in April 2023 that 29.4% of total ED attendances at Birmingham Heartlands Hospital were in the ED for over 6 hours. This was a consistent measure with the previous 2 months (February and March 2023) recording 30% of total ED attendances being in the department for over 6 hours.

The percentage of admissions achieving the 4 hours wait target was 42.9% (February 2023), 44.8% (March 2023) and 49.2 % (April 2023). Although this showed there was some progression, there were still challenges noted in achieving this target with over half the total admissions outside of this target.

The percentage of admissions waiting from 4 to 12 hours from decision to admit were 35.1% (February 2023), 37.5% (March 2023) and 39.2% (April 2023). This demonstrated there were still challenges with flow out of ED. The trust was aware of this and looking at how it could be improved further.

The trust had implemented a 'Push Model' across all 3 EDs. This aimed at increasing capacity within the ED by sending patients to other wards and departments each hour. For Birmingham Heartlands Hospital, 3 patients were expected to be moved out of ED per hour between 8am and 8pm. This decreased to 2 patients per hour after 8pm.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff tried to plan patients' discharge carefully, particularly for those with complex mental health and social care needs, however, challenges were noted. At the time of the July inspection; 2 patients, both attending for acute mental ill health had been in the department overnight awaiting ongoing care. The trust had completed a review of the time which patients experiencing mental ill health spent in the department in January 2023. This highlighted some concerns in relation to the length of time patients remained in ED, with the average total time for patients remaining in ED recorded as 743.6 minutes. Once a decision to admit had been made, patients in the ED waited on average 8 hours for a transfer to a mental health unit. This was noted to be the best performance out of the 3 EDs.

Learning from complaints and concerns.

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Patients told us they felt comfortable raising any issues with the staff caring for them at the time.

Staff understood the policy on complaints and knew how to handle them. Staff tried to resolve any complaints or concerns locally; however, they were aware of the escalation policy if this was required. Staff told us matrons were always made aware of any complaints or concerns which were reported.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. There was a band 7 staff member who was appointed to a role which reviewed and investigated complaints. Information shared after the inspection showed in April 2023, there had been 55 complaints reported which were in relation to Division 3a which covered the EDs. The main themes from these were:

- Waiting times.
- Broken vending machines.
- Lack of food and drink provision.
- Lack of pain relief whilst waiting to be seen.
- Communication and irregular updates.
- Privacy and dignity concerns.

We reviewed 3 complaints and the responses provided by the trust. We found the responses included apologies where necessary and also provided details on actions to take if those complaining were unhappy with the response. This included the details for the Parliamentary and Health Service Ombudsman. We also noted there was an acknowledgement that there were current delays within the complaints processes , again an apology for the delays in responding to the complainant was provided. Complaints were discussed during the triumvirate meetings, during the meeting held in March 2023, it was reported there were 7 complaints open which were going through the investigation process.

Urgent and emergency services

Managers within the service had supported a family communications project whereby a team of 4 staff communicate with relatives of patients to provide updates and information. Anecdotal information shared indicated this had made a significant impact to the number of complaints around communication and updates.

Despite staff telling us they received feedback, they were unable to share examples of where concerns and complaints had been used to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were mostly visible and approachable in the service for patients and staff.

Leadership for the emergency department (ED) came under Division 3, and was provided by the divisional medical director, divisional director of nursing and managing director. As the division covered a wide range of services, Division 3 was further divided into 3a and 3b. The EDs came under the structure of 3a and had further leadership structure of a deputy medical director, director of operations and deputy director of nursing, with matrons in support of the deputies. Staff told us divisional leads were knowledgeable about their main challenges and were focused on the importance of delivering high quality, safe care and treatment.

Most staff were complimentary about their immediate leaders and told us they were supportive, approachable and visible.

Some staff were complimentary about the impact which the chief executive officer in place at the time of inspection had on the trust. They had made themselves available for staff and had visited most areas and the sense of change had been observed.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Staff were generally aware of the trust's strategic aims to always put the needs and care of patients first and to "build healthier lives". Most staff were aware of the trust's overall strategy and vision and how this was reflecting in their own local areas. Progress against the strategy was monitored at the divisional governance meetings.

There was a set of values in place which involved being kind, connected and bold and staff knew where to look to find information on it.

Local leaders worked with stakeholders to develop plans to develop the service to meet the changing needs of the local population.

Urgent and emergency services

Culture

There had been an improvement in the culture within the ED since the last inspection. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with told us they felt valued, supported and respected by their leaders and their peers. Staff also made comments about 'having a family feel' to the team, 'working much closer together' and 'loving it here'. This is a significant change from the previous inspection where the culture was of a concern.

Staff told us there was an 'open door' approach to all managers and leaders in the ED. If there were any concerns, staff felt they were able to raise them without fear of reprisal. Some staff told us they were actively encouraged to speak up if they had concerns. Staff were also aware of the Freedom to Speak Up Guardian, although not all staff were aware of how to access the speaking up service.

Staff told us there was a focus on staff well-being and all staff, regardless of role looked out for each other. We were made aware of a significant incident which the staff had recently experienced; managers had ensured all staff were made aware of the support which was in place for them to access. This was reflected in the recent staff survey which identified 66% of staff working in all EDs felt secure in raising concerns. This was slightly higher than the trust overall average of 65%. There were no concerns raised during our inspection in relation to bullying or concerns in relation to equality and diversity. However, it was noted within the staff survey that there were concerns within the EDs where staff believed they were not always treated fairly or that different backgrounds were always respected.

The staff survey for 2022 was recently published at the trust. The results identified various positive results for the EDs, the top 3 were:

- The organisation made adequate adjustments to enable me to carry out work (92% positive responses).
- Always know what work responsibilities are (90% positive responses).
- Last experience of physical violence was reported (83% positive responses).

It was also noted that 37% of staff did not think about leaving the service regularly. Considering the challenging environment staff worked in and the pressures the trust were under, this is a significant response which indicates a more positive culture within the EDs.

There were some areas of concern identified within the staff survey, the top 3 were:

- I have realistic time pressures (10% of staff agree with this statement).
- Enough staff at the organisation to do my job properly (14% of staff agreed with this statement).
- Satisfied with level of pay (15% of staff agreed with this statement).

Despite the positive feedback in relation to well-being at this location, it was noted within the overall staff survey results that the section which identified burnout within staff all scored negatively within this. This indicated staff were experiencing burnout. Burnout is a state of physical and emotional exhaustion. It can occur when staff experience long-term stress in their job, or when they have worked in a physically or emotionally draining role for a long time.

Urgent and emergency services

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at higher levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, we were not assured information and learning was always disseminated.

Senior staff held regular meetings to discuss and learn from the performance of the service. Information received after the inspection identified regular meetings held at divisional level down to band 7 level. These meetings had routine agendas which included reviewing performance, patient experiences and risks and outcomes of the service. There was also evidence of issues which required escalation being escalated to trust level meetings and also board meetings. However, we were unable to identify exactly how information was disseminated within the ED. We observed copies of the 'Risky Business' newsletter on the department noticeboards which contained some details about learning from complaints for example. Noticeboards were however noticed to contain some old information which related to the previous trust or focused on clinical information. Staff reported there had been no ED staff meetings where important information and learning was shared.

Local audits were conducted in the ED for safeguarding, medicines, records, infection prevention and control/ cleanliness audits. The ED also had a dashboard which provided real time information on compliance with a range of standards including NEWS2, sepsis and falls. Leaders were due to review performance data at Clinical Dashboard Review Groups to develop communication for the wider staff group. However, this was on hold at the time of the inspection.

At the previous inspection it was identified there were challenges with the service discharging their regulatory responsibilities regarding duty of candour. Information from this inspection showed there had been some improvements in this, however, it was acknowledged that there was still work to do.

There had been no progression on the Accessible Information Standard from the inspection which was conducted in June 2021. Within the service we were told about a project which was being driven forward by an individual and supported by local leadership. However, there was no other active work underway to become compliant with this legal requirement.

There was no evidence that the service was addressing the issues related to the Cauda Equina pathway which was found to be not equitable to the pathway in one other ED at the trust.

The service reported challenges with completing mandatory training and had completed an action plan for managing the areas which required improvement. However, we noted there was no information on the action plan which covered the low compliance for training in relation to caring for patients with a learning disability, autism, dementia and mental ill health. This meant compliance with relevant training which had become a legal requirement in July 2022 was poor.

All service level agreements provided by 3rd parties were recorded within the trust financial accounts and governed through standing financial instructions for the financial aspects. The trust also held meetings with service providers to regularly review operational performance and clinical quality. For the ambulance decision area and hospital ambulance liaison officer (HALO) service level agreement the trust held daily meetings with the head of patient flow in conjunction with a dedicated matron for oversaw the services.

Urgent and emergency services

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact, however, we were not assured all risks had the right level of seriousness identified.

The service had an emergency medicine risk register which covered all 3 EDs. There were 11 risks documented on the risk register which included lack of support for mental health patients, safeguarding concerns, insufficient staff especially senior decision makers and the use of multiple information technology (IT) systems. The top risks were the IT system risk and the capacity and flow challenges which were regularly faced. There was evidence on the risk register and the governance meetings that risks were regularly reviewed and closed appropriately when all mitigation was complete.

Safeguarding concerns were identified on the risk register and given a reduced risk rating after mitigating actions taken into consideration. The details of the mitigating actions identified only increasing safeguarding training as the outstanding action before this could be closed. However, we were not assured the service had considered the seriousness of the safeguarding concerns and the ongoing missed referrals which continued to be identified each month.

Staff raised concerns about the safety of minors 2 which was always accessible to members of the public but had no dedicated security and the alarms only sounded in the immediate area. Despite this being raised as a significant risk, there was no acknowledgement of this on the risk register. We were therefore not assured the service had oversight of all risks.

There was a programme of clinical and internal audit to monitor quality and operational processes, however we were not assured staff of all levels had results of the audits shared with them.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff were able to access the trust intranet site to access any policies and procedures needed to carry out their roles effectively. However, these were not always up to date. Information governance training was including in the trust's mandatory training schedule.

There was a television in the waiting area, however, at the time of the inspection it did not display useful information such as length of waits.

The department collected reliable data and analysed it. Such information was used in audit processes and quality improvement projects.

Engagement

Leaders and staff actively and openly engaged with patients and staff, to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had developed an 'A&E Patient Experience Task and Finish Group' which was working to address the areas of feedback about the experiences which patients had when they attended all 3 EDs. Areas which had already been reviewed included chairs for patients when waiting, access to food and drink and cleanliness. The group was chaired by the head of patient experience and had both staff and patients represented within the group.

The lost property service provided enabled patients and their families to provide feedback and suggest improvements. We reviewed 6 feedback forms. All people completing the forms rated the service as 'excellent' and provided positive feedback.

Staff participated in the staff surveys. Results showed the hospital scored 18 positive scores which were the same or better than the trust average, 7 positive scores up to 3% below the trust average, and 71 scored 4% or more below the trust benchmark. Forty-three percent of staff reported they would recommend the organisation as a place to work and 83% of staff believed their role made a difference to those who used the service. A completion rate for this ED was not provided, however there were only 87 responses across the whole of emergency medicine at the trust.

Following the most recent staff survey results in April 2023, leaders told us they were currently working on an action plan in response to the survey and a follow up meeting was conducted in May 2023. As part of the actions which were recognised as being required following the recent survey, an ED staff forum was being set up where areas from the survey could be explored and improvements recognised.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We found staff were committed to improving the service they provided. Staff were locally encouraged to produce ideas on how the service could be improved. Leaders were receptive to the ideas and would often trial these locally before consideration for permanent implementation was given. Leaders told us the ideas staff came up with were impressive and demonstrated a desire to improve patient experience.

Staff of all levels and roles were involved in quality improvement projects, something which was long standing and which the service was proud of.

Examples of projects across the trust's EDs were a family communication project being trialled in ED to support patients and families to receive updates and information about their care and treatment, access interpreters where required. The team also supported patients with cognitive impairment, learning disability and mental ill health to communicate with clinical staff.

A further example specific to this ED was a lost property project led by a member of staff. A staff member who supported patients and their next of kin to retrieve lost or left property gave emotional support at potentially very distressing times such as following the loss of a loved one at ED. They contacted the patient and/ or next of kin offering a range of communication options and times to speak with the person. They offered a range of ways people could collect their property and if appropriate worked with next of kin to collect property such as sentimental items during viewings of a deceased loved one. They understood the importance of sentimental items and went over and above to locate items for patients and next of kin, such as an item of jewellery which contained the ashes of a couple's son which was misplaced during a visit to ED. Often patients or next of kin were distressed upon realising items were missing; the staff member kept regular contact with them.

Urgent and emergency services

The service held their 2nd research engagement day in June 2023 organised in collaboration with the research team. The whole ED service was involved currently with 6 research projects; however, Birmingham Heartlands Hospital ED were due to join 1 of these research studies imminently which focused on improving outcomes for adults with a significant traumatic head injury.

The service was working to improve their mental health pathways for the EDs. The service was linking in with other NHS trusts to learn from the work which they had done in this field.

To improve triage times the trust had implemented changes to ensure time critical and self-presenting patients were seen promptly. Changes included the implementation of a priority triage card kept by the triage nurse and navigator and reallocation of emergency care technicians to work directly with the triage nurse to complete urgent ECG's or blood tests.

The implementation of the Ambulance Decision Area had been viewed as an improvement project which had supported the system by improving the delays substantially for offloading patients from ambulances, ultimately improving the responsiveness for the local community. There was also the improvement in the patient experience at the ED as they were no longer being held in an ambulance for prolonged periods of time.

Maternity

Inadequate

Is the service safe?

Inadequate

The rating for safe is the rating from the previous inspection in June 2023. During this inspection we did not look at all aspects of the safe domain, we therefore had insufficient evidence to re-rate.

Environment and equipment

The Pregnancy Assessment Emergency Room (PAER) had relocated to a different area within the maternity building which improved the service for women and birthing people.

Since our inspection in February 2023, the PAER had relocated from the end of the delivery suite to what was the antenatal scanning service area. Staff were positive about this move and the impact it had on being able to deliver a better service for women and birthing people. The waiting area was now located within the PAER, which meant staff had visibility over those waiting. There were additional rooms where women and birthing people were located if they required monitoring. There was a designated room for triaging women and birthing people on their arrival. At time of peak activity, there was an additional area identified where a second staff member could triage them. This was a significant improvement from their location previously.

There were no call bells for women and birthing people to use in the PAER. The service had moved into the area where antenatal scanning had previously been located. As these rooms were only used for scanning purposes, there were no call bells required. During our inspection, we raised with the department manager there were no call bells for women to use should they require the attention from staff within the department. The manager was aware of this concern and told us a risk assessment had been completed for this. Staff told us they did not feel this was a concern as they were constantly going into the rooms to check on the women and birthing people, as well as to check any CTG (cardiotocography) recordings which were being recorded. All rooms were observed to have an emergency bell within them for staff to activate should emergency assistance be required. After the inspection, we requested the risk assessment which identified this to be a moderate risk. However, it was noted that the date on the risk assessment was 21 June 2023, which was after our inspection, and therefore the risk assessment was not in place at the time of our visit as previously advised. The mitigation on the risk assessment was in line with what the manager told us at the time with the addition of advising women and birthing people to utilise the emergency buzzer in an emergency. Having reviewed the rooms during inspection, it was noted that the emergency buzzer was not accessible from the trolley and therefore, may not always be a possible mitigation in each circumstance. The risk assessment indicated the new PAER, which was being completed at the time of our visit, will have call bells in place.

Staff did not always carry out daily safety checks on specialist equipment. Staff told us it was common for women and birthing people to attend the department in active labour and that there had been babies born in the department previously. On the day of our inspection, we spoke with a woman who had been told to attend the department due to a spontaneous rupture of membranes and frequent contractions. We reviewed the resusitaire within the department and found between 1 March and 13 June 2023, there were a number of days where this had not been checked to ensure it was working. March 2023 recorded the highest number of missed checks where 22 days were missed. There were 5 days

where checks were missed in April 2023, 15 days where checks were missed in May 2023 and 1 missed check recorded for June 2023. We escalated this to the ward manager during our inspection and the wider maternity team at the feedback discussion. We received information after the inspection which identified our concerns had been acted upon and stricter oversight of the checks was now in place from the matron and Director of Midwifery for the trust.

Staff told us the service had suitable facilities to meet the needs of women's families and also had enough suitable equipment to help them to safely care for women and babies. Since moving to the new area, staff told us they now had more suitable facilities to meet the needs of women and birthing people. However, the move was only temporary until the new PAER area had been renovated. Work was underway at the time of our inspection and was expected to be completed in December 2023.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks.

Staff completed risk assessments for each woman and birthing person on arrival to PAER. Staff now used a system to triage women and birthing people which was based on the Birmingham Symptom Specific Triage System (BSOTS). The risk assessments were paper-based documents which used the red, amber and green (RAG) system to identify the women and birthing people who were highest risk. There were specific time scales within which staff needed to review them according to the level of identified risk. Those identified as a red required medical review within 15 minutes of triage, amber required medical review within 60 minutes of triage and green required a medical review within 4 hours of triage. There had been significant challenges on the previous inspection for women and birthing people receiving timely medical reviews. On the day of our inspection, we found most women and birthing people were being seen in accordance with the recommended timeframes for review by medical staff. We reviewed 14 triage records and found evidence of a timely medical review in 5 records. There were 5 records where it was documented that a medical review was not required. The remaining 4 records were not completed accurately as times or RAG rating for the obstetric pathway were missing; we were therefore unable to confirm if they had been seen within the recommended time. We observed within some notes there was a difference between the time at which women and birthing people had been triaged and the time at which they had been seen by a midwife; however, this did not impact the issues we identified.

The service had been completing real-time audits to capture the data for when women and birthing people attended the service. This recorded key timings (arrival, triage, review by midwife and review by medical staff) as well as the RAG rating. Staff told us this commenced shortly after the inspection in February 2023 and had identified an improving trajectory in meeting the key timings for reviews, which meant an improving experience for the women and birthing people. Information shared with us after the inspection showed between 18 May and 21 June 2023 a medical review had been completed, where required, for 88% of all attendances exceeding the national target of 85%. There were 9 days where PAER was recorded to fall below the national target, with 6 June 2023 recorded as having the lowest recorded medical reviews within the specified time frame of 55%. Most of the breaches were recorded as a failure to complete a medical review for those who were identified as an amber risk (required a medical review within 60 minutes of triage), although there was 1 recorded red breach on 20 June 2023. All breaches were reviewed, and no harm was identified within any of the breaches.

Staff told us when they identified a breach was about to occur or if a woman or birthing person had breached the time for their triage or review, they would prompt the staff to highlight the need for intervention. Although most staff believed this was a positive use of the real time audit, some staff raised the concern over them being drawn away from women who needed the midwifery or medical attention more that the woman or birthing person who was now breaching.

Maternity

During the previous inspection, it was identified that women and birthing people had left the PAER due to the long waits they experienced for medical reviews. This raised concerns over the potential complications they were experiencing which may be missed. Due to the improved medical staffing within the department, staff told us women and birthing people rarely left the department prior to their medical reviews. We requested information after our inspection, and this showed there had been no reported incidents of women or birthing people leaving PAER due to delays with accessing a medical review. Staff told us there was a process in place to safety net anyone who left the department prior to being seen. Staff told us their names were added to the board and the doctors would contact them when they had an opportunity. If the information provided to the medical staff indicated they need further monitoring, they would be advised to return to the department.

Staff shared key information to keep women safe when handing over their care to others. The service had introduced morning huddles within the department to discuss key information which impacted on the safety and the running of the department. Staff told us these huddles were still "in their infancy" having only been implemented 6 weeks prior to the inspection. However, staff found they were useful to go through any women who may have arrived prior to the shift change over and to escalate any women and birthing people who were RAG rated red or amber who may have breached their review times. Staff told us the medical staff had not always attended these huddles. We requested minutes from the huddles which had been held however we did not receive these. We received information to demonstrate the huddles were due to be implemented and the aspects which were expected to be covered during them.

Medical staffing

The service had improved their medical staffing for the Pregnancy Assessment Emergency Room (PAER) to ensure they had the right numbers of staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had improved their medical staff within the PAER to keep women and babies safe. Information received before our inspection in response to the Section 29A Warning Notice showed the service was improving their medical staffing within the PAER and tried to ensure there were named medical staffing assigned to the PAER. The staffing rota provided showed between March and May 2023 there was always at least 1 doctor assigned to the area. However, they acknowledged there should be a registrar and junior doctor assigned each day between 8am and 8pm. Additional information provided after the inspection showed there were some gaps where only 1 locum doctor was assigned to PAER (27, 28 and 29 May, and 2, 3, 4, and 11 June). It was also noted on 2 June there was only a locum doctor assigned to PAER between 5pm and 8pm. In all rotas reviewed, there was always a designated consultant obstetrician who was identified for escalation purposes. Outside of these hours, midwives escalated their concerns to the on-call team.

The service leads had introduced a weekly workforce meeting to review the staffing rotas and to ensure there was safe medical cover. There was a core attendance at these meetings which were held virtually. Where gaps were identified in the rotas, actions were taken to address these. We requested minutes of these meetings and were provided with the document which highlighted any unfilled shifts and had details of actions identified to manage this. There were no additional notes or minutes taken from these meetings. Staff told us the rotas containing the names of doctors assigned to PAER were not shared in advance with the lead for the department which meant staff were not always sure which doctors were assigned to the area.

The medical staff matched the planned number. On the day of our inspection, the planned medical staffing for PAER of 1 registrar and 1 junior doctor matched the actual staffing. There was also a designated consultant identified for escalation. Staff told us since our inspection in February 2023, this was a regular occurrence now. Occasionally, the medical staff were called away to assist elsewhere in the service. For example, the day before our inspection, the

registrar was called to the delivery suite to cover whilst the second theatre was operating. Staff told us even on these occasions, there were always medical staff to escalate any risks to, including any women and birthing people who were deteriorating, and they would attend as a matter of urgency. They had not experienced any occasions when there was no one to escalate to or when someone would not attend PAER.

The service had reducing vacancy rates for medical staff. Since the inspection in February 2023, the service had recruited 6 new consultants, 1 of whom had since unfortunately withdrawn their application. In addition to this, 3 additional fixed term consultant positions were also being advertised to increase the consultant workforce. The improvements meant there was consultant cover for the service.

The service had low turnover rates for medical staff. Since our last inspection, none of the medical staff had left the service.

Sickness rates for medical staff were low. At the time of our inspection, there were no significant sickness concerns amongst the medical staff which were impacting the service. Information provided after the inspection recorded a current sickness rate of 0.03% for medical staffing within the whole of the maternity services.

Managers could access locums when they needed additional medical staff. The service still relied upon locum staff to cover all areas within the service. Managers made sure locums had a full induction to the service before they started work. Since the previous inspection, the requirement for locum consultant cover had reduced following a successful recruitment campaign and there were no locum consultants utilised. However, there had been an increase in the need for locum doctors to cover the junior staffing requirements. Between 18 May and 13 June 2023 there had been 23 locums used to provide medical cover out of a possible 46 shift requirements (this considered that on each shift there should be 1 registrar and 1 junior doctor).

The service always had a consultant on call during evenings and weekends. Staff were positive about the access to the on-call consultant and had not experienced any challenges when escalating concerns to them.

Records

Staff used a combination of paper and electronic records for documenting women's care and treatment. Paper records in PAER were not always completed accurately.

PAER used a combination of paper-based triage documents and electronic records systems to record the care and treatment women and birthing people received in the department. We reviewed 14 paper-based records at the time of our inspection and found there was significant information missing from 5 records. We found that 3 of the records had their RAG rating missing which therefore meant the risk to the woman or birthing person was not known (2 of these also had key timings missing). The remaining 2 records had key timings missing, including the triage time and the medical review time. We raised this with the staff in the department who confirmed that all timings and RAG ratings should be completed. Staff told us triage assessment documents were regularly audited. However, we raised with the manager that the accuracy of these audits would be in question as staff were regularly updating the assessment forms retrospectively as part of the real-time audit. This meant the manager would not get a realistic view of documentation accuracy and learning from any areas of concern.

When staff reviewed the women or birthing people, they documented their reviews on the electronic system as close as possible to the time they reviewed them. However, at the time of our inspection we were aware of notes which had not been completed in a timely manner. This meant it was important for staff to complete the key timings within the paper-based triage documents to ensure there was an auditable trail of accurate timings when women and birthing people were seen.

Incidents

The PAER service managed safety incidents well. Staff recognised and reported most incidents and near misses.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Since our inspection in February 2023 there had been 6 incidents raised: 1 graded as moderate harm, 1 graded as low harm and 4 graded as no harm. The trust highlighted the moderately graded harm incident had occurred in March 2023 and was prior to the move of PAER from the previous location. Staff did not routinely report all breaches of reviews by medical staff unless specific concerns were identified, for example failure to attend despite escalation. However, reviews of each breach were reviewed to determine whether there was an element of harm.

The service had not reported any never events within PAER or any related areas within the maternity service since our inspection in February 2023.

Staff reported serious incidents clearly and in line with trust policy. Since our inspection in February 2023, staff told us there had been no serious incidents reported. However, information received after the inspection showed there was 1 incident in March 2023 which was upgraded to a serious incident and was undergoing a thorough investigation. This incident had highlighted some challenges with accessing medical reviews and, as a result, the woman was delayed in receiving an urgent transfer to the delivery suite for an emergency caesarean section. It was noted that this serious incident occurred prior to the move of PAER and there had been no further serious incidents since the move.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong.

It was difficult to establish whether staff regularly discussed and received feedback from incidents due to the low numbers of incidents since our last inspection, especially serious incidents. However, there were still forums available for incidents to be discussed and look at how improvements to the care of women and birthing people could be made. Weekly risk meetings were held where incidents were discussed, and formal presentation of learning was conducted 4 times per year for the whole service. Key information and learning from incidents were also an item discussed at the newly implemented huddles within the department.

Is the service caring?

Good ➔➔

The rating for caring is the rating from the previous inspection in February 2019. During this inspection we did not look at all aspects of the caring domain, we therefore had insufficient evidence to re-rate.

Maternity

Compassionate care

Staff treated women with compassion, kindness and dignity, and took account of their individual needs. However, we were aware of confidentiality issues during our inspection.

Women said staff treated them well and with kindness and took time to interact with them and those close to them in a respectful and considerate way. We spoke with 3 women and 2 relatives who were all complimentary about the staff they had seen. There were no concerns expressed over the waiting times to be seen in the PAER. They told us staff were sensitive towards them and were considerate of the circumstances which had brought them into the department. Information requested after the inspection in relation to patient experience identified between April and June 2023, indicated there were minimal concerns around the caring nature of the staff in PAER. Most respondents identified the midwives were friendly, helpful, and prompt in their care. There was 1 response which identified they had waited too long, in their opinion, for a review by a doctor.

Staff were not always discreet when discussing and caring for women. Staff did not always keep women's care and treatment confidential. During our inspection, we spent time in the waiting area of the PAER speaking with women and birthing people and relatives who may have come with them. Whilst chatting with them, we were able to overhear confidential conversations going on between staff and women as well as discussions about women and birthing people's care and treatment happening between staff. It was noted that at the time of our inspection, there was a heatwave which meant all doors were left open as much as possible due to the lack of air conditioning within the department and trying to ensure rooms did not get too warm for women and birthing people.

Is the service well-led?

Inadequate

The rating for well-led is the rating from the previous inspection in June2023. During this inspection we did not look at all aspects of the well-led domain, we therefore had insufficient evidence to re-rate.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and had taken action to make improvements within the Pregnancy Assessment Emergency Room (PAER).

It was reported following the inspection in February 2023 that there had been a period of instability within the leadership. The new Director of Midwifery (DOM) had now taken up post within the service and it was fed back by staff that they had already made an impact on the service.

Leaders understood the priorities of the service and took immediate action to make the necessary improvements. Action was immediately taken to improve the medical staffing for the PAER which in turn had improved the experiences of women and birthing people.

Governance

Leaders operated governance processes which gave them regular opportunities to meet, discuss and learn from the performance of the service. However, we were not assured the governance processes were always effective.

The triumvirate continued to meet monthly. We reviewed the last 3 sets of minutes of these meetings and found there were agenda items where challenges within PAER specifically could be discussed as well as incidents and any medical specific concerns. However, the minutes were brief in some sections and did not reflect any learning or outcomes of discussions held. Incidents, for example, only had their incident identification number recorded with no details of what was discussed or learning from these. Within the minutes of the governance meeting, it was also noted there was no recognition of the inspection which occurred within the service in February 2023 and the actions required to improve.

Amongst the information, which was shared after the inspection, we observed some discrepancies which raised concerns over the service's governance systems for producing accurate information about performance. The real-time audit data showed that on 22 May 2023 there were 5 amber breaches recorded with the maximum time of breach recorded as 75 minutes. However, within the data provided on incident reports, we observed a no harm incident which indicated there were 2 women and birthing people who were seen by a medical member of staff 83 and 90 minutes later than required.

Since the last inspection, the service had improved their triage system; the process ensured those who required a more urgent assessment were escalated accordingly. As part of our information requests, we requested the standard operating procedure (SOP) for the triage service. However, the document provided was the SOP which was in place for maternity services at Good Hope Hospital which they were hoping to adopt at this location. We were therefore not assured there was a SOP currently in place to support the triage process at Birmingham Heartlands Hospital.

Management of risk, issues and performance

Leaders and teams had systems to manage performance. They identified and escalated most risks and issues and identified actions to reduce their impact. However, we were not always assured that these were well managed or actioned in a timely manner.

During our inspection, we found a risk within the temporary area being used for PAER as there were no call bells within the assessment rooms. Staff told us this had been considered and a risk assessment completed. However, the risk assessment received after the inspection identified the date of the risk assessment being completed was 21 June 2023 which was after our visit. We were therefore not assured that risks were always being identified and assessed in a timely manner.

The service had a risk register in place which included mandatory training, non-compliance with Ockenden and staffing vacancies. However, we observed that not all risks were recorded and were not assured the risk register was regularly reviewed. Through our monitoring of the trust, we were aware of issues in relation to doctors in training within this service. However, there was no risk identified on the register which appeared to address this despite the seriousness of this risk and impact on the service. We also observed open risks in relation to vacant posts for a director of midwifery; this position had been recruited into but had not been updated on the risk register. The risks on the risk register did not have any risk owners assigned to them which meant there was a possibility of risks not receiving the oversight and drive to mitigate these. This reflected a concern observed on the inspection in February 2023. We also noted the risk register did not identify any environmental risks in relation to call bells despite the risk in relation to PAER being updated.

The minutes of the maternity governance meetings identified areas where performance was scrutinised by those attending. There was information documented around performance for key training and risk assessments; however, there was no specific information recorded to have been discussed around the performance within triage. The real-time

audit had produced some quality data around the performance in relation to both midwifery and medical times for reviewing women and birthing people. However, this appeared to have not been included within the governance meetings. We were therefore not assured triage performance was being reviewed in relation to the risks identified during the last inspection and the required improvements which were necessary.