University Hospitals Birmingham NHS Foundation Trust

Inspection report

Queen Elizabeth Hospital Birmingham
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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 hospital trusts 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 acquisition took place on 1 April 2018. The combined organisation has a turnover of £1.6 billion and provides acute and community services across four main hospitals:

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

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

The trust has 2,366 in-patient beds over 105 wards in addition to 115 children's beds and 145 day case beds. The trust operates 7,127 outpatients' and 304 community clinics per week.

The trust has over 20,000 members of staff.

The trust had experienced significant challenges over the past 18 months due to the COVID-19 pandemic. The trust had treated over 14,000 COVID-19 positive patients, of those 2,830 were COVID-19 related deaths. Over 1,500 staff were redeployed from substantive roles to care for the most acutely ill patients and support staff in critical areas. Services had to be redesigned and moved at short notice.

Our findings

At the time of our inspection, the number of patients admitted to the trust with COVID-19 had significantly reduced. Although throughout the three weeks of core service inspections, the number of patients admitted with COVID-19 had started to increase again.

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

- Urgent and emergency care at Good Hope Hospital, Birmingham Heartlands Hospital and Queen Elizabeth Hospital Birmingham because we had concerns about the quality of services,
- Medicine at Good Hope Hospital because we received information giving us concerns about the safety and quality of the services,
- Cancer services because we received information giving us concerns about the safety and quality of the services. This core service is not aggregated to form the overall trust ratings.
- Surgery (focused) at Queen Elizabeth Hospital Birmingham because we had concerns about the quality of services.

We also inspected the well-led key question for the trust overall.

We did not inspect several services previously rated requires improvement because this inspection was focused only on services where we had concerns. We are monitoring the progress of improvements to services and will re-inspect them as appropriate. Services previously rated as requires improvement and not inspected this time include:

Birmingham Heartlands Hospital

- Medical care (including older people's care)
- Surgery
- Maternity

Good Hope Hospital

- Surgery

Solihull Hospital

- Urgent and emergency services

Community Health Services

- Community health services for children and young people
- Community end of life care

Our rating of services went down. We rated them as requires improvement because:

- We rated effective, caring and well-led as good and safe and responsive as requires improvement. Well-led is the overall trust-wide rating, not an aggregation of services ratings.
- We rated two out of six services inspected as good, three as requires improvement and one as inadequate.

Our findings

- 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 only inspected one core service at Birmingham Heartlands Hospital and two at Good Hope Hospital, therefore it would not be proportionate.
- Patients were not always protected from harm. There were significant handover delays for patients arriving by ambulance and for those who self-presented to the department. Services did not manage medicines well. Not all staff had received mandatory and safeguarding training, however work was ongoing to improve this.
- Individual needs were not always met. People could not always access the service when they needed it and received 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.

However:

- 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.
- 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 June and July 2021. We visited areas relevant to each of the core services inspected and spoke with a number of patients and staff, as well as holding focus groups.

During the inspection we visited 10 areas for cancer services at Queen Elizabeth Hospital Birmingham, 13 for medical services at Good Hope Hospital, 13 for surgery services at Queen Elizabeth Hospital, four for urgent and emergency care at Good Hope Hospital, five for urgent and emergency care at Birmingham Heartlands Hospital and three for urgent and emergency care at Queen Elizabeth Hospital Birmingham.

We spoke with 210 staff members of various speciality and profession including, consultants, doctors, radiotherapists, nurses, healthcare support workers, pharmacists, patient experience, domestic staff and administrators.

We spoke with 56 patients throughout the departments and reviewed 95 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.

Our findings

Outstanding practice

We found the following outstanding practice:

Queen Elizabeth Hospital Birmingham Cancer Services

- The cancer services were working towards reducing patient backlogs by providing faecal immunochemical test *(*FIT) and intradermal (Skin cancer) services.
- Trial testing called the “Grail test”, which is a blood test that can diagnose over 50 types of cancer.
- The trust had recently approved a purchase of a new ultraviolet cleaner for the oncology and haematology wards, this created assurances following on from recent COVID-19 outbreaks at the trust.
- The haematology department had commenced an ambulatory autograft pathway to reduce backlog that began in April 2021, this includes the division acquiring the use of three self-contained apartment based at the Queen Elizabeth hospital site to provide support for patient on this treatment pathway, this was part of a mutual aid project with other joint accreditation committee ISCT-Europe (JACIE) accredited centres. JACIE is Europe’s only official accreditation body in the field of haematopoietic stem cell transplantation and cellular therapy.
- The dietetic teams altered their practice to try and prevent admissions to the oncology wards reviewing patients virtually. They also supported the nurses with inserting nasal gastric tubing in patients undergoing radiotherapy and chemotherapy in an outpatient setting to prevent patient to have further weight loss and prevented hospital admissions.
- The Ecosystems project was to host a suite of materials including sepsis secrets podcast, videos and interactive page to promote further awareness on sepsis.

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.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 21 legal requirements. This action related to six services.

Good Hope Hospital Medical Care

- The trust must ensure nurse staffing levels meets the needs of patients in all areas, especially the health care for older people wards. (Regulation 18 (1))
- The trust must ensure the individual needs of people with vulnerabilities are met, especially on the health care for older people wards, with appropriate assessment, planning and delivery of person centred care, with provision of information by appropriate communication approaches in an environment suitable for their needs. (Regulation 9)

Good Hope Hospital Urgent and Emergency Care

Our findings

- The trust must ensure that staff working in the minors department are safe. (Regulation 17 (2)(b))
- The trust must ensure the service follows medicines are administered and stored safely. (Regulation 12(2)(g))
- The trust must ensure the service has pharmacy input in order to maintain compliance with the medicines management policy. (Regulation 12(2)(g))
- The trust must ensure staff are aware of and understand accessible information standards (Regulations 9(1)(b)(3)(d)(h))
- The service must not nurse patients on corridors without an appropriate standard operating procedure and risk assessments. (Regulation 17(2)(b))
- The service must manage risks appropriately and listen to advice given with regards to fire safety. (Regulation 17(2)(b))
- The service must keep patients records and information secure to maintain confidentiality. (Regulation 17(2)(c))

Birmingham Heartlands Hospital Urgent and Emergency Care

- The trust must ensure the premises are suitable for the purpose for which they are used. (Regulation 15 (1)(c))
- The trust must ensure medicines are stored safely. (Regulation 12(2)(g))
- The service must manage risks appropriately and listen to advice given with regards to fire safety. (Regulation 17(2)(b))
- The trust must ensure it improves flow into, through and out of the hospital to reduce the time patients spend in the department. (Regulation 12(1))
- The service must ensure patients are treated with dignity and respect. (Regulation 10(1))
- The service must operate effective governance systems to ensure compliance with all relevant sections as set out in Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17(1)

Queen Elizabeth Hospital Birmingham Urgent and Emergency Care

- The trust must ensure consistently carry out daily safety checks of specialist equipment. (Regulation 12(2)(e))
- The trust must ensure consistently follow systems and processes when prescribing, administering, recording and storing medicines. (Regulation 12(2)(g))
- The trust must ensure it improves its management of risk and issues and ensure they can plan effectively to tackle patient safety issues. (Regulation 17(1))

Queen Elizabeth Hospital Birmingham Cancer Services

- The trust must ensure all intravenous fluids in resuscitation trolleys are stored securely. (Regulation 12).

Queen Elizabeth Hospital Birmingham Surgery

- The trust must ensure clinical waste, including sharps bins, is appropriately stored and disposed of safely. (Regulation 12(1)(2)(h))
- The trust must ensure all clinical areas and equipment used by patients are appropriately cleaned and disinfected according to national standards, infection control guidelines and local policies. (Regulation 15(1)(a)(2)

Our findings

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure recruitment processes are open and transparent and are able to evidence recruitment processes for senior positions. (Regulation 19 (2))
- The trust should ensure action is taken regarding identified themes to resolve concerns. (Regulation 17 (2)(e))
- The trust should ensure duty of candour is applied as soon as reasonably practicable after becoming aware of a notifiable safety incident. (Regulation 20 (2)(a))
- The trust should ensure disparities are reviewed, assessed and mitigated against with a clear plan to deliver. (Regulation 17 (2)(b))
- The trust should ensure all risks are escalated as appropriate and documented on the relevant risk register. (Regulation 17 (2)(b))
- The trust should ensure actions are implemented across the trust and system that improve the flow of patients into, through and out of the emergency departments and hospitals. (Regulation 17)
- The trust should consider the way in which it communicates with staff when discussing issues raised.
- The trust should consider the way in which lessons learnt are shared.
- The trust should consider the way in which the council of governors are utilised to ensure the chair and non-executive team are held to account.
- The trust should consider the mixed views of staff with regards to culture and take appropriate action.

Good Hope Hospital Medical Care

- The trust should ensure completion of ReSPECT documentation is carried out in all areas in accordance with trust policy. (Regulation 11 (1))
- The trust should ensure completion of nursing risk assessments is carried out in all areas in accordance with trust policy. (Regulation 12 (2)(a))
- The trust should ensure Health and Safety risks, including fire risks, are minimised in all areas in accordance with trust policy. (Regulation 12 (2)(d))
- The trust should ensure medicines are stored in accordance with trust policy in all areas and that required checks are carried out and documented. (Regulation 12 (2)(g))
- The trust should ensure all areas maintain confidentiality of patient sensitive information (e.g. on ‘whiteboards’ and computer terminals). (Regulation 17 (2)(c))
- The trust should ensure medical staff achieve compliance with the trust’s target for safeguarding, mental capacity act and deprivation of liberty safeguards training. (Regulation 18 (2))
- The trust should ensure all staff achieve compliance with the trust’s target for Prevent training. (Regulation 18 (2))
- The trust should ensure all staff achieve compliance with the trust’s target for fire safety training. (Regulation 18 (2))
- The trust should consider employment of either dual registered staff or having Registered Mental Nurse staff available in the Acute Medical service for advice and support.

Our findings

- The trust should consider patient moves due to non-clinical reasons are minimised and have appropriate data recorded with regard to this.

Good Hope Hospital Urgent and Emergency Care

- The trust should ensure medical staff keep up to date with their mandatory training, including safeguarding training. (Regulation 18 (2)(b))
- The trust should ensure staff have additional training in which could help to de-escalate situations or prevent injury. (Regulation 12(1))
- The trust should ensure the room for mental health patients is ligature free. (Regulation 15 (1)(c))
- The trust should ensure it continues to work towards ensuring all staff have a yearly appraisal. (Regulation 18 (2)(b))
- The trust should ensure it provides continuous professional development to nursing staff within the department. (Regulation 18 (2)(b))
- The trust should ensure it works toward the national target of 95% performance against the four-hour target to treat, admit or transfer a patient from when they arrive at the department. (Regulation 12(1))
- The trust should ensure that the service has access to languages other than English in various sources. (Regulations 9(1)(b)(3)(d)(h))
- The trust should ensure it improves its management of risk, issues and performance of the division and ensure they can plan effectively to tackle patient safety issues. (Regulation 17(1))
- The trust should consider reviewing staffing levels for porters within the department.
- The trust should consider how it obtains confidential patient information when patients are in the waiting area and outside the department.

Birmingham Heartlands Hospital Urgent and Emergency Care

- The trust should ensure it continues to work towards all appropriate staff receiving the relevant safeguarding training. (Regulation 18 (2)(a))
- The trust should ensure it continues to work towards ensuring all staff have a yearly appraisal. (Regulation 18 (2)(a))
- The trust should ensure it provides continuous professional development to all staff within the department. (Regulation 18 (2)(a))
- The service should ensure staff work are familiar with and act in accordance with the Mental Capacity Act 2005 and associated principles. (Regulation 11(3))
- The trust should ensure the service has access to a variety of sources for patients whose languages are other than English. (Regulations 9(1)(b)(3)(d)(h))
- The trust should consider how to promote an inclusive culture within the department.

Queen Elizabeth Hospital Birmingham Urgent and Emergency Care

- The trust should ensure all staff are up to date with their mandatory training (Regulation 12(1))
- The trust should ensure that the service has access to languages other than English in various sources. (Regulations 9(1)(b)(3)(d)(h))

Our findings

- The service should ensure appraisal rates are improved in line with action plans. (Regulation 18 (2)(a))
- The trust should ensure patients can access emergency services when needed or receive treatment within agreed timeframes and national targets. (Regulation 12(1))
- The trust should ensure that patients in the waiting room are monitored to identify any deterioration in health. (Regulation 12(1))
- The trust should ensure staff improve when following important measures to avoid the transmission of harmful germs and prevent health care-associated infections. (Regulation 12(2)(h))
- The trust should ensure all relevant staff are aware of their role and responsibilities with regards to sepsis identification and management. (Regulation 12(2)(a))
- The trust should consider how to promote an inclusive culture within the department.
- The trust should consider how to report all incidents including near misses to facilitate learning and improvement.
- The trust should consider ensuring all patients receive a consistent level of pain management.
- The trust should consider the availability of specialist meals for patients who require these.

Queen Elizabeth Hospital Birmingham Cancer Services

- The trust should ensure all staff have opportunities to complete all their mandatory training and make sure everyone completed them. (Regulation 12)
- The trust should ensure all staff complete their safeguarding training. (Regulation 13)
- The trust should ensure there is always enough staff on duty to keep patients safe from harm. (Regulation 18)
- The trust should ensure staff complete all patient documentation and ensure they are kept up to date. (Regulation 17)
- The trust should ensure it continues to work towards national targets, so patients are able to access services as required (Regulation 12(1))
- The trust should consider the Patrick room facilities to ensure all patients have access to the service.
- The trust should consider updating some department signage for the public on site to reflect the new movement of services in the departments to prevent additional worry for people. For example, chemotherapy day unit now in Eastblock not sixth floor in the main Queen Elizabeth Hospital.
- The trust should consider alternative pathways when admitting patients over 24 years of age to the young person unit.

Queen Elizabeth Hospital Birmingham Surgery

- The trust should ensure all staff complete their mandatory training, including safeguarding. (Regulation 12)
- The trust should ensure all patients admitted as emergency admissions are screened for MRSA (Regulation 12)
- The trust should ensure MUST, falls and pressure ulcer risk assessments are completed for all patients. (Regulation 12)
- The trust should ensure all medicines are stored securely and medicines trolleys are not left unlocked and unattended. (Regulation 12)
- The trust should ensure all patients receive pain relief promptly. (Regulation 12)

Our findings

- The trust should ensure all patient records are store securely and not left unattended in public view. (Regulation 17)
- The trust should ensure all staff receive their yearly appraisal. (Regulation 18)
- The trust should consider how incidents external to the service and subsequent learning is shared.
- The trust should consider regular input from the wider MDT across all areas of the service.
- The trust should consider how low-level risks are routinely reviewed and monitored.

Is this organisation well-led?

Our rating of well-led went down. We rated it as good because:

- Leaders had the skills and abilities to run the trust.
- The vision and strategy were focused on sustainability of services and referred to working with providers within the wider health economy to improve patient pathways.
- Staff were focused on the needs of patients receiving care.
- Leaders operated effective governance processes, throughout the trust and with partner organisations.
- Leaders and teams used systems to manage performance. They predominately identified and escalated relevant risks and issues and identified actions to reduce their impact.
- Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.
- 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 and strived to be influences on improved patient outcomes.

However:

- Staff had mixed views regarding the visibility, how approachable trust leaders were, and the transparency of processes followed by leaders.
- There was a mixed perspective from staff regarding feeling respected, supported and valued. Including the actions taken as a result of raising concerns.
- Further work was required regarding disparities between sites following the acquisition of Heart of England NHS Foundation Trust.
- Some risks were not escalated as appropriate and documented on the relevant risk register.
- The executive team were aware staff engagement needed further development.

Leadership

Leaders had the skills and abilities to run the trust. They understood the priorities and issues the trust faced. Staff had mixed views regarding the visibility and how approachable trust leaders were. They supported staff to develop their skills and take on more senior roles.

Our findings

- The leadership team had the capability to deliver high-quality services, which included an experienced group of non-executive directors. They understood the priorities and issues they faced.
- Non-executive directors told us over the past 18 months, they were able to respect the autonomy that was required to give to the executive team to take relevant action to keep patients safe throughout the COVID-19 pandemic.
- Some of the leaders modelled inclusive and empathic leadership styles. The chief nursing officer had a strong focus on compassionate leadership and developing staff. This included career development opportunities for facilities staff and healthcare assistants, as well as development of a school of nursing.
- The executive team were frequently requested to take on additional responsibilities external to the trust. Over the last 18 months, the trust had also led on the NHS Nightingale Birmingham project, the COVID-19 vaccination programme and provided support to another NHS trust which was in special measures. The trust planned to devolve authority and accountability to divisional structures and was considering the organisational development needed to support this process. This would ensure the capacity of its executive team remained sufficient.
- Staff we spoke with during the core service inspections provided mixed views regarding the visibility of the leadership team, including how approachable they were.
- We reviewed eight personnel files in line with Fit and Proper Persons Requirement: Directors (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and found appropriate employment checks had been made.
- Executive and non-executive directors were also required to complete an annual self-declaration, to confirm they did not fall into the definition of an “unfit person” or any other criteria set out in the guidance. We reviewed evidence to confirm this was completed.
- We received concerns regarding the openness and transparency of recruitment processes for senior positions. Although senior personnel files demonstrated appropriate employment checks were carried out before a person commenced in their role, there was no evidence to demonstrate the recruitment process, we were advised of two new posts in which staff were promoted without a recruitment process. In one instance, there was also no job description or contract of the new role the person had been appointed to.

Vision and Strategy

The trust 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 and referred to working with providers within the wider health economy to improve patient pathways. Leaders and staff understood and knew how to apply them and monitor progress.

- The trust had a vision for what it wanted to achieve and the strategy in place was due to be reviewed in the forthcoming year due to the COVID-19 pandemic and restoration phases.
- The trust’s strategy ‘to build healthier lives’ was a multi-year strategy and was in line with the trust’s direction. The strategy referred to the Birmingham Hospitals Alliance to bring together acute and specialised providers within the Birmingham and Solihull area to work collaboratively on a range of clinical and non-clinical projects. Although it documented the importance of working with external stakeholders, it was unclear how stakeholders had been included in the development of the strategy.

Our findings

- The executive team was clear around the importance of quality and recognised and spoke eloquently about strategic uncertainties within the integrated care system. Executive and non-executive directors spoke persuasively regarding solutions being within the health and social care system and the need to work as a system to drive forward future improvements for patients. The need to work collaboratively was also emphasised within the strategy.
- The board and senior leadership team recognised the ongoing uncertainties in developing long term plans but were aiming to create certainty wherever possible for the benefit of patients and staff.
- Most staff within divisions were aware of the trust strategy and how they fitted into achieving the overall strategy. They were also aware of the overarching priority to restore services following the COVID-19 pandemic.
- There was no trust wide pharmacy strategy, although the chief pharmacist was clear about the vision for the service and had a number of business cases to help with the development.
- Several service changes had been taken at pace in response to the pandemic, however, the executive team recognised any future changes would require consultation.
- The acquisition of Heart of England NHS Foundation Trust by University Hospitals Birmingham NHS Foundation Trust in 2018/19 and recent changes to the contracting and financial architecture of the NHS led to a delay in the development of a long-term financial plan to support the strategic implementation plan.
- While the trust has managed considerable challenges including the acquisition and the significant impact from the COVID-19 pandemic on operational performance, the financial management and governance implications continue to present ongoing challenges.
- Non-executive directors expressed uncertainties about the financial future and how this impacted on the ability to plan, especially around elective surgery recovery plans.

Culture

There was a mixed perspective from staff regarding feeling respected, supported and valued. Staff were focused on the needs of patients receiving care. The trust was at the start of its equality and diversity agenda in daily work and provided opportunities for career development. The trust promoted an open culture where patients, their families and staff could raise concerns without fear, however not all staff felt comfortable raising issues.

- There was a mixed perspective from staff regarding feeling respected, supported and valued. Staff were focused on the needs of patients receiving care and opportunities for career development were available.
- Trust leaders spoke clearly about compassion for the wellbeing of staff and the need to be inclusive, empathic and compassionate. We heard about historic leadership being control and demand and executives recognised the need to change.
- All those we spoke with were concerned about and recognised, following the pandemic, the workforce was tired and continued support was required to ensure their wellbeing. This included ensuring psychological support was available to all staff.
- Senior leaders identified poor staff performance promptly and took relevant action. There had been a significant change in culture specifically around how poor work performance was managed, to support the person affected. Work was being carried out to change the language used regarding disciplinary processes.

Our findings

- The trust promoted an open culture so patients, their families and staff could raise concerns without fear and be involved in all aspects of care. Policies were in place to support raising concerns and reviewed with stakeholders. However, some staff told us they felt some leaders were distant and when they did listen nothing changed, therefore they felt unsupported.
- As a result of workforce race equality standard, the trust had several action points in place which included, but was not limited to, the development of a chief executive officer fairness taskforce and the development of a Birmingham and Solihull Integrated Care System multi ethnic and system leadership programme.
- The audit committee in March 2021 noted delays in the implementation of a report from internal auditors regarding the equality, diversity and inclusion agenda and noted it did not appear to have sufficient traction. We heard how the equality, diversity and inclusion agenda was at the start of its journey and needed to move at pace to achieve the desired outcome of fairness. This included detail around the implementation, monitoring and assurance behind the strategy. The trust was clear an inclusive culture was paramount to improving outcomes for all patients and reducing health inequalities, championing inclusive practice and challenging non inclusive behaviour.
- The trust's Freedom to Speak Up Guardian reported themes of concerns raised to the board of directors. During 2020/21, the freedom to speak up service received 117 contacts (0.5% of employed staff). The main concerns related to problematic attitudes and behaviours. It was also noted a large proportion of those contacts were junior doctors. It was unclear within minutes from the board of directors what action was being taken to address the concerns the freedom to speak up service were raising.
- The executive team recognised more needed to be done to ensure Freedom to Speak Up resources were available and used by all groups of staff.
- We reviewed nine serious incident investigations and noted the investigations were thorough and evidenced duty of candour had been applied. Although we did note for one of the incidents, there was no evidence of verbal notification.
- Quarterly reports of duty of candour compliance across all seven divisions demonstrated poor performance against both parts of the duty of candour, which included completing duty of candour within 10 working days. However, this included incidents that were categorised as no and low harm which do not fall into the requirement of regulation 20 of the health and social care act. Performance for completing duty of candour (for both verbal and written notification) across the divisions within 10 working days ranged from 25% to 83% within quarter four 2020/21. This included both verbal and written notification.
- Following our inspection, the trust provided additional data regarding duty of candour. We saw of the 183 incidents audited and reported, 159 were categorised as a notifiable incident. Of those, 145 received verbal notification within 10 working days and the trust were aware of the reasons for why verbal notification was delayed.
- We carried out a staff survey from 7 June 2021 to 21 June 2021 which focused on culture and leadership. There were 931 completed responses, which equates to 4.2% of the total staff employed, and 360 incomplete responses. Over 50% of staff responded positively to their immediate manager encouraging them at work and being encouraged to be open and honest with patients and staff when things go wrong. Reponses for all other questions in the survey were less positive however noting these respondents were a small number of the total staff employed, whilst respecting and acknowledging their responses we were unable to come to any significant conclusions.

Governance

Leaders operated effective governance processes, throughout the trust and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Our findings

- Leaders operated effective governance processes, throughout the trust and with partner organisations. Staff were clear about their roles and responsibilities and had opportunities to meet, discuss and learn from the performance of the services.
- The executive team spoke of a unitary board, therefore worked to a collective responsibility for aspects such as finance and patient quality and safety.
- The trust was an executive led and data driven organisation. There was a strong emphasis on quantitative data, however this was less apparent with qualitative data.
- There was a clear scheme of accountability and delegation, which set out the executive responsibilities and clear delegated limits. Although, we noted this was due for review in April 2021.
- The council of governors were represented on the care quality group which reported to the clinical quality committee. However, we noted they were not represented on the clinical quality monitoring group which also report to the clinical quality committee, nor were they represented at the clinical quality committee. Therefore, we were not assured the trust had the necessary openness required to challenge and provide independent scrutiny.
- Information regarding workforce was a little remote from the board however we were advised the board had recently recognised a greater focus was required and were addressing it.
- The board assurance framework focused on strategic risks in line with the trust's strategy, links were also evident between some of the strategic risks and defined corporate risks. Risk owners at executive level were responsible for providing quarterly updates on mitigating actions through the board of directors meeting and regular assurance was sought through other internal committees of the board.
- Through the utilisation of internal auditors, the trust was provided with assurance regards to their risk processes and board assurance framework.
- Following the acquisition of Heart of England NHS Foundation Trust in April 2018, staff felt there were still clear disparities in processes and guidance across the relevant sites. While the pandemic meant progress regarding refining consistencies across the sites had been delayed, there remained a concern as to how these disparities impacted on patient safety.
- Medicines management policies in place were not aligned across the trust and this had been highlighted as a priority for the medical safety officer.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They predominately identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions.
- The identification, documentation and understanding of risk was generally captured with good processes for clinical and patient risk.
- The corporate risk register clearly identified the risk score and the division and or specialty it related to. While the corporate risk register did not identify a person responsible for the risk, the chief operating officer sought assurance from clinical specialties and divisions in line with the trust's policy and reported these to the board of directors.
- Clinical specialty risk registers were generally well maintained, and risks were escalated in line with the trust's policy.

Our findings

- The trust predominately identified and escalated relevant risks and issues and generally identified actions to reduce their impact. For example, risks identified on the pharmacy risk register did not have clear actions planned or timescales to address them. We also noted findings from safe and secure handling of medicines audits were poor but were not highlighted as a risk within pharmacy or trust level. Some of the highest risk scores on the corporate register related to capacity for patients waiting for transplantations and for those attending the accident and emergency department. From the findings of the three urgent and emergency care inspections we were not assured that the trust had the necessary actions in place to manage the risk the demand was driving,
- There was a positive incident reporting culture across the services we inspected. Action plans following investigation of incidents were clear. However, we noted not all learning from incidents was shared across the entirety of the trust.
- The trust's learning from deaths process was established and the reporting structure was adhered to.
- Plans were in place to ensure the trust could cope with unexpected events.
- The trust has historically delivered the financial expectations agreed.
- Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Information Management

The trust collected reliable data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- The trust had a rich supply of data with effective information technology systems to support this, which included financial performance. Reporting included a wide range of performance indicators and used statistical process control analysis, identified special cause variation and supported data quality assurances.
- There was a comprehensive and clinically led clinical information system which brought all clinical patient information together for easy review of patient care and treatment. The system had data quality processes in place to support efficiency and effectiveness and was in place across 50% of the trust with completion of the roll out planned for the end of 2021.
- There were robust arrangements in place for cyber security, which was supported by root cause analysis and lessons learnt for incidents and near misses.
- Detailed reports were generated for quality improvement, monitoring and assurance and discussed at board level.
- The Caldicott function worked closely with the senior information risk owner (SIRO) and processes were in place to ensure data was protected and requests for access to patient records were handled lawfully.

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- The trust engaged with patients, staff, the public and local organisations to plan and manage services and collaborated with partner organisations. However, some staff felt they were not listened to. We heard how staff understood why changes had to be made at pace over the last 18 months, however communication regarding these changes had not always been positive.

Our findings

- It was widely recognised by the executive team engagement over the last 18 months had been challenging. Structures were in place for staff engagement and this was an area of focus to improve by the executive team.
- A patient experience strategy had recently been approved which aimed to support the trust's vision. The strategy had been developed through discussions with patient, carer and community councils, council of governors and through reviews of patient feedback and complaints.
- The trust was engaged with the local integrated care system with a clear focus on integrated place arrangements. The executive team recognised the importance of wider partnership working to secure sustainability of clinical services.
- The council of governors varied in their views regarding holding the chair and non-executive team to account. Some felt although papers were often complicated due to the complexity of the trust, they could still challenge and seek assurances. Others felt often decisions were made and that the council of governors were informed about decisions and not engaged with to plan and manage services.
- Friends and Family Test (FFT) data was shared with all departments as well as the patient experience group. The trust generally received a good amount of responses, predominately within inpatients and emergency departments. In April 2021, 96% would recommend inpatient services, 94% would recommend outpatient services, 77% would recommend emergency services and 100% would recommend community services.

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 and strived to be influences on improved patient outcomes.

- There was strong focus and success with innovation and technological solutions to problems and to improve patients care and ultimately outcomes.
- Digital technology innovation was embedded throughout the trust and the executive team were clear this was a way to improve patient pathways.
- The trust was committed to a digital transformation strategy, for example we heard how the dermatology service had been improved using artificial intelligence reducing the number of patients waiting on the two-week-wait list.
- The trust was committed to improving services by learning from when things when they went well, and when they went wrong.
- Leaders were able to demonstrate learning from safeguarding reviews, incidents and complaints to improve patient practice.
- Those leading on root cause analysis investigations had received relevant training to ensure incidents were investigated thoroughly and actions identified.
- From December 2020 to May 2021, the trust received 829 complaints across all services. Reports were provided for divisions, as well as for the chief executive advisory group which focused on broader themes.
- We reviewed 10 complaints and noted all were investigated and responded to in line with the trust policy.
- From December 2020 to May 2021, the trust received 1,002 compliments across all services. Compliments were shared with any named individuals as well as service leads for the team or department.
- The trust had 25 accreditations, which ranged across medicine, surgery, children and young people and other clinical services.

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 ↓ Oct 2021	Good ➔➔ Oct 2021	Good ➔➔ Oct 2021	Requires Improvement ↓ Oct 2021	Good ↓ Oct 2021	Requires Improvement ↓ Oct 2021

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
Acute locations	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ↓ Oct 2021	Good →← Oct 2021	Good →← Oct 2021	Requires Improvement ↓ Oct 2021	Good ↓ Oct 2021	Requires Improvement ↓ Oct 2021

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 ↓ Oct 2021	Good →← Oct 2021	Good →← Oct 2021	Requires Improvement ↓ Oct 2021	Good →← Oct 2021	Requires Improvement ↓ Oct 2021
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
Overall trust	Requires Improvement ↓ Oct 2021	Good →← Oct 2021	Good →← Oct 2021	Requires Improvement ↓ Oct 2021	Good ↓ Oct 2021	Requires Improvement ↓ Oct 2021

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 2019	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	Requires Improvement ↓ Oct 2021	Good →← Oct 2021	Good →← Oct 2021	Requires Improvement →← Oct 2021	Requires Improvement ↓ Oct 2021	Requires Improvement ↓ Oct 2021
Outpatients	Good Feb 2019	Not rated	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019
Cancer services	Good Oct 2021	Good Oct 2021	Good Oct 2021	Requires Improvement Oct 2021	Good Oct 2021	Good Oct 2021
Overall	Requires Improvement ↓ Oct 2021	Good →← Oct 2021	Good →← Oct 2021	Requires Improvement ↓ Oct 2021	Good →← Oct 2021	Requires Improvement ↓ Oct 2021

Rating for Birmingham Heartlands Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Requires improvement Feb 2019
Maternity	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Requires improvement Feb 2019
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 ↓ Oct 2021	Good →← Oct 2021	Requires Improvement ↓ Oct 2021	Inadequate ↓ Oct 2021	Requires Improvement ↓ Oct 2021	Inadequate ↓ Oct 2021
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
Urgent and emergency services	Requires Improvement Oct 2021	Good Oct 2021	Good Oct 2021	Requires Improvement Oct 2021	Requires Improvement Oct 2021	Requires Improvement Oct 2021
Medical care (including older people's care)	Requires Improvement Oct 2021	Good Oct 2021	Good Oct 2021	Requires Improvement Oct 2021	Good Oct 2021	Requires Improvement Oct 2021
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 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.

Queen Elizabeth Hospital Birmingham

Mindelsohn Way
Edgbaston
Birmingham
B15 2GW
Tel: 01216271627
www.uhb.nhs.uk

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 major, 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.

Urgent and emergency 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 were up to date with the mandatory training programme. This was linked to the COVID-19 Pandemic; an action plan was in place to address this.

Nursing staff received and kept up to date with their mandatory training. However non-clinical staff groups did not meet the trust training target.

The overall compliance for mandatory training was 85%. Nursing staff were 91% compliant, additional clinical service staff were 91% compliant and non-clinical were 68% compliant. The target was 95%. This meant the trust could not be assured all staff had the right knowledge and skills to carry out their duties in the safest ways possible in order to minimise any risk to themselves and others. However, managers had produced an action plan to address the shortfall which had occurred due to difficulties in releasing clinical staff, staff turnover and social distancing requirements.

Medical staff were not up to date with their mandatory training. An action plan was in place to rectify this.

Medical staff were 70% compliant with their mandatory training. This meant the trust could not be assured all medical staff had the right knowledge and skills to carry out their duties in the safest ways possible in order to minimising any risk to themselves and others. However, managers had produced an action plan to address the shortfall which had occurred due to difficulties in releasing staff, staff turnover and social distancing requirements.

The mandatory training was comprehensive and met the needs of patients and staff. Staff received training that was determined essential by the trust for the safe and efficient delivery of services. The training was designed to reduce organisational risks and comply with local and national policies and government guidelines

Clinical staff completed training on recognising and responding to patients living with mental health needs, learning disabilities, autism and dementia. This was included in the mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was a planned approach in the department to increase the mandatory training rates. For example, managers were encouraging all the staff to use any available time to complete mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Nursing staff received training specific for their role on how to recognise and report abuse. Overall, there was 88% compliance with level two safeguarding children training. Nursing staff were 97% compliant with level two safeguarding children and additional non-clinical staff were 93% compliant.

Nurses were 76% compliant with level three children's safeguarding training.

Nurses were 82% compliant with safeguarding adult training and additional clinical staff were 63% compliant.

Medical staff did not meet the training target specific for their role on how to recognise and report abuse. Medical staff were 58% compliant with level two children's safeguarding and 79% compliant with level three.

Managers had produced an action plan to address the shortfalls which had occurred due to difficulties in releasing staff, staff turnover and social distancing requirements.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff professional standards of practice and behaviour were underpinned by values of equality and diversity. This meant staff treated people as individuals, avoided making assumptions about them, recognised diversity and individual choice, and respected and upheld their dignity and human rights.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff demonstrated detailed awareness of the principles of safeguarding and their responsibilities. For example, where patients had complex social care needs or staff identified potential safeguarding risks at home, they liaised with the safeguarding team and other multidisciplinary colleagues to ensure patients were protected.

Staff were supported with up-to-date policies for the protection of adults. They supported staff to identify different types of abuse and provided guidance on the provider's policies and procedures. Guidance supported staff to report abuse to external organisations such as the local authority who could take action to investigate concerns. There was reference to local and national guidance and the legal responsibilities for staff.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.Staff could contact the safeguarding team for advice and support. They provided advice, training and support for all areas of safeguarding. Staff accessed safeguarding policies on the trust's intranet and requested further support from the trust's safeguarding team if necessary.

Staff followed safe procedures for children visiting the ED. Only the children of patients admitted to the department could visit. Children were always accompanied by an adult.

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 kept equipment and the premises visibly clean.

All areas, including clinical areas, were visibly clean and had suitable furnishings which were clean and well-maintained. Staff spoke highly of domestic and housekeeping staff and they were present across the department on the day of our visit. This meant staff could request timely deep cleans and decontamination.

The service generally performed well for cleanliness. For example, staff reported no cases of MRSA or other hospital associated infections between December 20 and May 2021.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. All the areas we visited showed cleaning was up to date. Cleaning audit data supported this.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff appropriately used personal protective equipment such as aprons and gloves. We saw these were readily available, which staff confirmed. Staff were 'bare below the elbow' in accordance with the trust's infection prevention and control policy.

Processes were in place to keep patients and staff safe during the pandemic. For example, the navigation nurse took the temperature of all patients entering the department and all staff carried out a lateral flow test before each shift. Symptomatic patients were swabbed and isolated immediately at the onset of symptoms.

Although we observed staff following policies regarding hand hygiene, audit results from December 2020 to May 2021 showed compliance between 88% and 92%. This meant staff were not consistently following important measures to avoid the transmission of harmful germs and prevent health care-associated infections.

Not all staff knew who the local infection prevention and control leads were.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to identify when an item of equipment had been cleaned was ready for use.

Environment and equipment

The environment was designed to suit the needs of the ED. Staff managed clinical waste well. However, safety checks on equipment in the resuscitation area were m not always completed.

At the time of our inspection, due to the covid-19 pandemic, patients were being held on ambulances outside of the department. This was due to a lack of available space and resources within the department as a consequence of the pandemic. Since the inspection, data from the trust showed actions had been taken to alleviate this such as opening more ward space.

Patients within the department could reach call bells and staff responded quickly when called. Patients said they received prompt support when they called for assistance.

The design of the environment followed national guidance. The service had a room specifically for patients at risk of suicide or self-harm or presenting with severe symptoms of mental health in the 'majors' area.

We reviewed a fire risk assessment for the department conducted in April 2021. This rated the department risk as 'moderate'. However, we saw not all actions had been complied with requiring the fire risk assessor to prompt leaders for a response.

Staff did not consistently carry out daily safety checks of specialist equipment. For example, staff did not consistently document safety checks on equipment in the resuscitation area. This meant the service could not be assured resuscitation equipment was always serviceable and ready for use. The departments own audits confirmed what we found. Missing checks were identified and escalated to nurse in charge. However, managers told us following the inspection they had not reached the end of their current audit period and that they would develop action plans at the end of the audit cycle.

The service had enough suitable equipment to help them to safely care for patients. For example, leaders provided three additional defibrillators to the aerosol generating procedure resuscitation area as part of the COVID-19 response. Also, as part of the COVID-19 response, some areas had been moved about in ED and therefore so had equipment based on clinical activity in the current/reconfigured area.

Staff disposed of clinical waste safely. Staff stored, handled and disposed of sharps in line with the Health and Safety Executive Sharps Instruments in Healthcare Regulations 2013. For example, staff labelled sharps disposal containers.

Assessing and responding to patient risk

Staff did not consistently monitor patients held on ambulances outside the department. For those patients within the department, staff undertook risk assessments. They removed or minimised risks and updated the assessments.

We observed patients were being held on ambulances outside of the department. This was due to a lack of available space and resources within the department. Whilst paramedics stayed with the patients and undertook clinical observations, we found there was very little oversight from trust staff. Data from the trust demonstrated there were protocols in place to direct nursing and medical staff to visually assess and review patients held on ambulances. However, at the time of the inspection we were not assured patients were being seen in line with this protocol. Post inspection, managers reiterated the protocols to staff to mitigate this risk for example during handovers. The trust also had action plans in place to address this risk. For example, they were in the process of recruiting another band six navigator nurse.

The remainder of this sub-section refers to patients in the department.

The median time from ambulatory (walk in) attendance at ED to initial assessment was five minutes across the trust for May 2021. This was better than the English average which was eight minutes for the same period.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff used the National Early Warning System (2) (NEWS2) tool to detect deteriorating patients. This early warning scoring system was based on routine physiological observations. The scoring of these observations provided staff with an indication of the overall status of the patients' condition. Where patients demonstrated deterioration according to these scores, nursing and medical staff took prompt action.

Staff followed a sepsis pathway to assess patients who triggered as at risk. In records we reviewed, staff had used this pathway appropriately. Not all staff we spoke with were confident in their knowledge about sepsis and when to escalate the care of patients with deteriorating conditions. Staff understood how to access the sepsis guideline on the trust's intranet.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. However not all patients in the waiting room were consistently monitored.

The triage nurse performed a brief assessment and allocated a triage category indicating the level of urgency of the presenting problem (how long the patient can wait to be seen by a doctor) when patients first presented to the ED. Plans were in place to recruit health care assistant grade staff to support this area of risk.

Navigation nurses and triage nurses were responsible for monitoring the patients in the waiting room. Staff told us these staff did not always have time to do this consistently. We saw that reception staff were unable to see the majority of the patients to visually recognise if a patient suddenly significantly deteriorated. Plans were in place to recruit more healthcare assistant grade staff to support this area of risk.

Staff knew about and dealt with any specific risk issues.

Between March and May 2021 staff recorded 57 patient falls. The percentage of attendees who fell in the department ranged from 0.24 to 0.39%. Managers also analysed the falls by further categorising the falls to mode, age range and contributory factors. Department managers and leads had action plans in place to further reduce the number of patients falls. For example, they planned to trial the use of alarmed seat pads in ED to see if these would help to alert staff to patients who might get up unaided.

The service had 24-hour access to mental health liaison and specialist mental health support. If staff were concerned about a patient's mental health, they could access these services.

All staff could make referrals to the rapid assessment interface discharge (RAID) team who were based in the hospital for any patient aged 16 years and over with presumed mental health or substance misuse needs. However, staff at all levels said there were delays in discharging patients presenting with mental health symptoms due to lack of external resources and increased ambulance demand. In addition, although risk assessments were completed, there were not always enough staff to support the needs of the patients to reduce their risk.

When a patient presented to the department with a mental health concern, they had an enhanced risk assessment completed. During this risk assessment, the risk of the patient was rated low, medium or high risk. If a nurse had any concerns regarding a patient, these were escalated to the nurse in charge and matron as required.

Once the patient had been seen by the liaison psychiatry team, an in-depth handover was provided to the ED nursing team including the risk for the patient and risk of absconding. At this point, if it was felt the patient would benefit from a registered mental health nurse providing one to one supervision this would also be handed over and escalated to the nurse looking after the patient, the nurse in charge and documented on the electronic patient notes for action. When a registered mental health nurse was required, these shifts were requested either by the ED senior team and authorised by the divisional team or the site team out of hours. In the period between January 2021 and May 2021, four registered mental health nurses were requested for the Queen Elizabeth Hospital emergency department.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The mental health team provided a variety of services including advice on alcohol problems, substance misuse treatment and assessment of care needs of older people living with mental health problems.

Staff shared key information to keep patients safe when handing over their care to others. This included the patient's diagnosis and their treatment plan.

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 had enough nursing staff to provide the right care and treatment. However, the trust had a high bank usage to mitigate this. 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 which could impact on patient safety and quality of care.

The nurse in charge would move staff depending on the demands of the department to ensure areas in peak demand were provided with additional staff to maintain patient safety. If this was unable to happen due to pressure across all areas of the department, this was escalated through the matron to the site lead and the division for assistance. If the department was unable cover any staffing shortfall, staffing across the division on the site was reviewed by the deputy director of nursing and they moved staffing accordingly. If it could not be resolved divisionally, staffing was reviewed and adapted across divisions through the site leads.

However, during phase one of the pandemic there were changes to the stroke configuration with centralisation of hyper acute stroke to the ED. Phase two had seen several services begin to plan for change and centralisation such as vascular, thoracic, trauma and orthopaedics and stroke. This led to an increase in ambulance presentation of trauma patients to the ED site, without subsequent increase in the number of nurses and clinicians in the ED.

The trust reported by the risk register that nursing skill mix cover was a risk at the time of our inspection. The nurse in charge would move staff depending on the demands of the department to ensure areas in peak demand were provided with additional staff to maintain patient safety. This was due to a higher number of junior nurses as compared to senior, more experienced nurses. Band seven nurses spent more time supporting these staff, hence less time available to complete management duties.

We saw on the risk register; an external review of nursing staffing had recommended that an education support staff member be recruited to reduce this risk; however, this was not accepted locally. Additionally, the use of experienced band three (not qualified as a nurse) staff was also supported to support skill mix where appropriate.

The service did not have enough staff to monitor patients at risk of self-harm or suicide as per risk assessments. This had led to some patients absconding from the department before being seen.

The emergency department had a full staffing review completed in August 2020. This was reviewed annually and reviewed at times across the year if it was felt there was an increased demand on the department. Staffing numbers on shift were reviewed biweekly and reviewed by the matron and the division. There was a clear escalation plan within the ED staffing. This had recently been completed and additional staffing had been added to the current establishment. This allowed for a second navigator and more healthcare assistants to assist with the ongoing care of patients within the department.

The service had low vacancy rates for nursing staff. There was a -12.5% vacancy rate for qualified nurses which meant nurses were over recruited. The vacancy rate for health care assistants was 9.91%. The trust identified vacancy rates of over 5% as high.

The service had low turnover rates. Turnover was calculated based on the number of leavers between May 2020 and April 2021 divided by staff in post (headcount). This showed 4.6% turnover for nursing staff and 5.5% turnover for healthcare assistants. The trust turnover target was 8.5% therefore turnover was lower than this.

The service had high sickness rates for health care assistant grades. Sickness was calculated as the number of whole time equivalent (WTE) days lost divided by the number of WTE days available during the month. This showed 5.2% for qualified nurses and 19.3% for health care assistants.

The service had high rates of bank and agency nurses. Managers could book enhanced rate bank staff and book external agency staff as part of the escalation procedure. This ensured safe staffing.

Managers made sure all bank and agency staff had a full induction and understood the service. Agency nurses were given an information leaflet welcoming them to the department and explaining the structure of the department and expected tasks to complete.

Medical staffing

The service, using locums, 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. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe without regularly using locums. For consultant medical staff, figures included staff who had other duties and who also had roles on other sites. As of May 2021, there were 19 senior medical staff and 52 junior medical staff. Consultants said it was challenging to ensure there were enough junior doctors at night.

We found although there was an X-ray and CT scanner in the department there could be delays in the patient journey when they were referred to radiology services. This was because there was only one radiologist reporting results and ED shared this service with the AMU. This meant there was a delay in referral times and receiving results. The matron was putting forward a business case to employ a second radiologist.

The service did not always have a good skill mix of medical staff on each shift, but this was reviewed regularly. It was recorded on the risk register that there was an insufficient number and skill mix of senior decision makers which could impact upon quality and safety of care. However, the trust had action plans in place to address this risk. For example, daily use of locums to cover vacant shifts and continued efforts to recruit staff.

Managers could access locums when they needed additional medical staff. Consultants told us the trust supported the use of locums, but they needed to appoint one full time consultant to ensure safe staffing and continuity of care.

Due to the use of locums, the actual medical staff in the department matched the planned number. Medical staff and junior staff said there was always enough medical support in the ED. Between December 2020 and May 2021, the department used 1,572 agency locum hours and 2,106 banks locum hours.

Managers made sure locums had a full induction to the service before they started work. Processes were in place to ensure locums had an understanding of the trust's systems to make sure they could deliver safe, effective and efficient care to patients.

The service had low vacancy rates for medical staff. There was a 2.5% vacancy rate for junior doctors.

The service had low turnover rates for medical staff. The turnover rate for senior medics was 5.3%.

Sickness rates for medical staff were low. Sickness rates for medical staff was 0.3%.

The service always had a consultant on call during evenings and weekends. Junior doctors and nurses confirmed they could always contact a consultant for advice or support.

Records

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

During the inspection period, we found staff did not update patient records for patients held on the back of ambulances until the patient was in the department. This meant there was no documentation to evidence any care or treatment by the trust staff despite the patient being under their care. Staff did, however, take copies of the paramedics' observations to include as part of the patient record.

The information below relates to patients within the department following a review of two records.

Patient notes were comprehensive, and all staff could access them easily.

Although formal documentation audits were suspended due to the pandemic, the senior team had assurances around records within the departments through a process of spot checks and communication to all staff of what was expected. If any gaps were found when reviewing notes at a later date for governance reasons, staff would be contacted and informed of the standards required and further training offered.

When patients transferred to a new team, there were no delays in staff accessing their records.

An electronic patient note system meant all patient information was available electronically, on screen, at any hospital location, at any time.

Records were stored securely.

We did not see any data breaches during our visit

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not consistently follow systems and processes when prescribing, administering, recording and storing medicines.

There was guidance for staff about prescribing, supply, dispensing, handling, storage, administration, disposal and auditing of medicines within the trust. Guidance referred to latest best practice and guidance from professional bodies. However, staff did not follow the policy to ensure medicines remained safe and effective and storage did not support timely access.

Staff did not consistently record fridge temperatures. They did not record maximum and minimum readings. This meant only a running temperature was available. Not all staff used the standard trust forms for recording fridge temperatures which included the appropriate prompts. Where staff were using the correct forms in one area, the correct readings were still not being recorded. This was not in line with the providers policy.

Where liquids should have been dated on opening, we found dates were not being recorded. This meant the medicine could be used past the point at which it would have expired. Staff we spoke to were not aware of the expiry date of the medicine we identified.

We found out of date medicines on one of the three emergency trolleys and in one hypo kit. The trolleys were not tamper evident. This meant items could be removed without staff being aware. The emergency kits (anaphylaxis, cardiac etc) were tamper evident.

We found out of date items were found in the hypoglycaemia cupboard in the resuscitation room. These were two bottles of control solution for blood glucose testing machines and one pot of ketone test strips. This meant the provider could not be assured these remained safe and effective to use.

The May 2021 safe and secure handling on medicines audit was reported on 20 May 2021 to the matrons. The audit identified some of the same issues we found. However, there were no action plans put into place to address these risks. The audit did not identify risks in relation to poor fridge monitoring practices. This meant we were not assured of the effectiveness of these audits.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff did not always store and manage medicines and prescribing documents in line with the provider's policy. For example, we found untidy cupboards and trolleys including loose blisters of medicines and loose vials. We found a selection of loose vials in a cupboard in the 'majors' drug room. They were separate from the other vials and staff we spoke to were not aware of the reason for them being in that cupboard. In all but one of the cupboards we inspected we found loose blisters.

Staff followed current national practice to check patients had the correct medicines. Staff described a process for medicines reconciliation when a patient was being admitted from ED to medical wards. A pharmacist from the AMU came to the department to undertake medicines reconciliations. Staff described handovers alerting all staff to ensure patients on extended stays on the ward using time sensitive medicines received their treatments.

There was no regular pharmacy service to the ED, a pilot in July 2020 had demonstrated the benefits of this service including time saved for nursing and medical staff (5.7 hours a day) and timely access to high risk or time sensitive medicines for patients. This had not been continued or rolled out on a permanent basis.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Medicines safety incidents were shared across the department and across the trust. A medicines link nurse had been appointed with a role in sharing incidents and leading improvements. We spoke to staff who told us medicines incidents would be reported though their incident reporting electronic system. Staff were aware of investigations and lessons learnt; however, they did not report near miss incidents. This meant themes could not be identified.

Incidents

The service managed patient safety incidents well. Staff recognised and mostly reported incidents and near misses 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.

Urgent and emergency services

Staff knew what incidents to report and how to report them. Staff gave examples of incidents they had reported, confirming this. This included patient falls, safeguarding concerns, medicine incidents and patients displaying aggressive behaviour. Staff reported 1,890 incidents over a 12-month period up to June 2021. The top three incident were pressure ulcers, admission discharge and transfer and non-adherence to standards.

Staff raised concerns and reported incidents in line with the trust policy. However near miss incidents around medicines management were not always reported. Staff knew how to reports incidents though the incident reporting IT system. Incidents reported included those where the incident had occurred before arrival such as community acquired pressures.

The service had no never events within the department. This meant staff followed national guidance on how to prevent serious patient safety incidents.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy. Serious incidents had been reported and recorded in the previous 12 months in line with policy.

Staff at all levels understood the duty of candour and the main principles of the regulation. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The providers policy for the reporting and management of incidences instructed staff to be open in an honest and timely fashion and patients and relatives were to be asked if they had any questions they would like answered in an investigation.

The service demonstrated how they met the duty of candour regulation. This regulation requires health service bodies to act in an open and transparent manner when things go wrong. Duty of candour was a standing agenda item in governance meetings. This showed managers had oversight

Staff received feedback from investigation of incidents, both internal and external to the service. Managers shared feedback through a variety of channels such as huddles, handovers, emails and a communications folder.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers completed root cause analysis (RCA) investigations to determine how and why a patient safety incident had occurred. Root causes are the fundamental issues that led to the occurrence of an incident and can be identified using a systematic approach to investigation. Contributory factors related to the incident may also be identified. We reviewed the previous three RCAs completed by the service. They looked at what, why and how it happened. They identified areas for change and developed recommendations, with the aim of providing safe patient care. Involvement and support for patients and relatives formed part of the RCA process.

Managers debriefed and supported staff after any serious incident. Staff said local managers were supportive and they would debrief staff after involvement in incidents such as a traumatic resuscitation.

Managers shared learning with their staff about never events that happened elsewhere. Managers shared information with staff through a variety of ways including a closed social media group and the senior teams had created a mobile app group to communicate and immediately share information.

Urgent and emergency services

Safety Thermometer

There was no safety thermometer data available for the ED department as this national tool was designed to audit and monitor the quality of care in inpatient areas.

Is the service effective?

Good

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

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 up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, staff carried out a computed tomography (CT) scan for each trauma patient. This was in line with Royal College of Physicians (RCP) guidance. A physiotherapist attended each trauma call in line with trust policy. The specialist respiratory physiotherapy team worked with respiratory consultants to deliver care in line with British Thoracic Society (BTS) quality standards for acute non-invasive ventilation (NIV) in adults, including effective intubation. The team applied the standards set out in the RCP national chronic obstructive pulmonary disease (COPD) audit programme as a benchmark for care to monitor the timeline from the patient presenting at the emergency department (ED) to the time of admission.

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

Staff used the SBAR (Situation-Background-Assessment-Recommendation) technique which provided a framework for communication between members of the health care team about a patient's condition. This always included a patient's mental health needs.

Nutrition

Staff mostly gave patients enough food and drink to meet their needs and improve their health. The service did not always make adjustments for patients' religious, cultural and other needs.

Staff mostly ensured patients had enough to eat and drink, including those with specialist nutrition and hydration needs. One patient said the trust did not cater for specialist nutrition needs such as gluten free meals in ED.

Patients varied in their views of food and drink provision; some patients were actively offered this whereas others had to request themselves.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff had access to fluid and hydration charts in the departments and used them where necessary.

Staff could access support from trust dietitians if needed.

Pain relief

Staff mostly assessed and monitored most patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools 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. However, not all patients received pain relief as it was required. Not all patients were actively asked about their pain levels.

Emergency nurse practitioners (ENPs) were nurse prescribers and administered pain relief to patients who presented with minor injuries.

Staff prescribed, administered and recorded pain relief accurately. Audits were carried out to ensure staff were following national standards for ED pain relief as set by the Royal College of Emergency Medicine. For example, medical staff audited the pain management of patients with renal colic in the Emergency Department audit. We saw evidence of learning and changes in practice in response to audit results.

Patient outcomes

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

The service participated in relevant national clinical audits. This included the Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma audit.

The trust told us data was submitted to the Royal College of Emergency Medicine (RCEM) for the Queen Elizabeth Hospital covering three audits. These were Fractured Neck of Femur (2020-2021), Pain in Children (2020-2021) and Infection Control (2020-2021). The Pain in Children audit was still ongoing, and data was currently being submitted. The study period for this audit would end on the 3 October 2021. In regard to the Infection Control and Fractured Neck of Femur audits, the reports were currently being produced and RCEM were anticipating they would be released around the end of July. The department were also planning to participate in the Consultant Sign off (2021-2022) and Mental Health (Self Harm) (2021-2022) audits.

Managers and staff used the results to improve patients' outcomes. For example following an audit of the Assessment, Management and Discharge Planning of Acute Asthma Exacerbations in Adults in the Emergency Department, a proforma was produced to guide clinicians in the assessment, management and discharge planning of adult patients attending with acute asthma exacerbations to the Emergency Department had been developed. The aim of this was to improve compliance with the guidelines and thereby improve patient outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff carried out a programme of clinical audit to find out if healthcare was being provided in line with standards and to let care providers and patients know where their service was doing well, and where there could be improvements. For example, medical staff carried out an audit to look at staff compliance with trust standards and guidelines for a GP referral letter.

Managers used information from the audits to improve care and treatment. Action plans and changes in practice were made following all the clinical audits we reviewed

Managers shared and made sure staff understood information from the audits. These were shared through a variety of channels such as team meetings and emails.

Improvement was checked and monitored. For example, in relation to the audit of analgesia for patients with fractured neck of femur, medical staff carried out a re-audit in July 2020. Two previous audits had been undertaken aimed to improve practice in this area. Processes had been put in place to improve this area. The auditors reported they were keen to assess the impact these changes had on departmental performance, especially after the COVID-19 pandemic. They therefore wanted to assess whether standards were being maintained.

The service had a lower than expected risk of re-attendance than the England average. The number of unplanned re attendance rates within seven days between March 2021 and June 2021 ranged from 6% to 8%. Up to May 2021, the England average was 8.2%.

Competent staff

The service worked towards ensuring staff were competent for their roles. Not all staff were appraised due to the pandemic. Managers and clinical educators held supervision meetings with staff to provide support and development.

Nursing staff were supported to become experienced, qualified and have the right skills and knowledge to meet the needs of patients.

The department had a team of link nurses for newly qualified nurses, who undertook regular peer led meetings to provide support and education to them.

Due to the pandemic some staff found it difficult to find the time to complete work towards their revalidation. Much face to face training had been cancelled; therefore, staff had to complete alternative e-learning modules or wait for face to face sessions to re-start.

Managers gave all new staff a full induction tailored to their role before they started work. This provided new starters with a structured and supportive method of introduction to the trust and department. The induction communicated the trusts strategic directions, policies and procedures and included an introduction to their role and their immediate work area. The trust process for locum doctors included a local induction checklist to follow when a locum first started work. The trust also provided them with an induction pack containing essential information.

Although not all staff had received an appraisal due to the pandemic, managers had action plans in place to support staff to develop through yearly, constructive appraisals of their work.

Due to the pandemic, only 41% of qualified nurses and 60.7% of non-trainee medical staff had received an appraisal. The department had action plans in place to improve compliance. The appraisal process re-started in April 2021, as per national guidance.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Staff received the support, professional development and supervision that were necessary for them to carry out their role and responsibilities. However, as in staffing we saw that nursing skill mix was on the risk register for the department due to a higher number of junior staff. Staff were supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show they met the professional standards needed to continue to practise. Managers discussed how staff could develop their performance and contribute to the development of the organisation and its values.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Every area had a consultant in charge. Junior doctors were required to discuss all patient cases with a senior colleague before deciding to admit or discharge a patient. This ensured ongoing clinical supervision and ensured patient safety.

Two clinical educators supported the learning and development needs of staff across three sites. They were responsible for a variety of training and development duties in the department. Much of their work focused on ensuring nurses had the skills and training to succeed in their individual areas. For example, they provided ongoing mentorship and served as examples to students through various stages of hands-on learning. We saw on the risk register that a business case for recruitment of more clinical educators was in progress.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Apart from the European Trauma course and the Advanced Life Support, all training had been delivered by the departmental clinical educators. Topics included trauma support practitioner, European Trauma and the Manchester Triage. In addition, all newly started nurses had completed a full day of local induction and orientation and at least two drug rounds on AMU to complete their medicine management sign off.

Managers made sure staff received any specialist training for their role. Nurses adopted link or champion roles in specialist subjects. This included clinical and non-clinical subjects, such as infection control, learning disabilities, tissue viability and safeguarding. Clinical educators ensured new staff were prepared for their roles. For example, they led basic trauma awareness training with new recruits in preparation for the trauma course which they would complete at the four to six month point in their new career.

Managers identified poor staff performance promptly and supported staff to improve. Managers referred underperforming staff to the clinical educator who offered training and support to them. They could also extend preceptorships by three weeks for staff struggling to adapt and settle into their new role.

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. For example, staff attended safety huddles. These were short multidisciplinary briefings, held at a pre-arranged time and place, and focused on the patients most at risk

Staff at all levels and from all disciplines worked together to deliver person centred and coordinated care and support for the person with care needs. For example, therapists worked closely with their ED colleagues and attended to trauma patients. The older people assessment and liaison team (OPAL) service was made up of a consultant geriatrician, specialist registrars, first year doctors, nurses and advanced healthcare practitioners.

Urgent and emergency services

The range of specialties supported the medical team with a broad range of clinical needs, which reduced delays in assessing initial needs and establishing admission or discharge plans.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Emergency department staff could make referrals to the mental health team for any patients aged 16 years and over with presumed mental health or substance misuse needs.

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.

The ED staff aimed to ensure equity in care for patients regardless of the day of the week, through supporting the spread of new models of seven-day services across the department.

As per the letter from NHSE/I in March 2020 the trust paused assessment and self-certification of seven-day services audit, and this remained the case at the time of our inspection. We reviewed the previous assessment completed in 2019. The department had implemented action plans such as consultant directed diagnostics to implement the seven-day standards.

Data from the trust reported there had been no reductions in access to services and interventions since the last assessment in 2019.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Patient ambassadors advised patients with minor illnesses that did not need admittance to the department on a range of conditions that could be treated at home with the right medication. Examples included sore throats, coughs, colds and mild stomach upsets.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Patient education was provided through leaflets and websites to help patients make decisions on their own care in the future.

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.However, medical staff were only 42% compliant with training in this area.

Urgent and emergency services

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood a patient lacked capacity if their cognitive functioning was impaired to the extent the patient was unable to make a decision at that time.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. For example, staff asked patients for their permission before they received any type of medical treatment, test or examination.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Where treatment was immediately necessary to save a life or to prevent a serious deterioration of a patient's condition, a best interest decision was reached.

Staff made sure patients consented to treatment based on all the information available. If a decision was not time-critical, consideration and a delay in initiating treatment would not be detrimental to the patient's wellbeing, their consent was secured in advance, so they had time to understand the procedure and ask questions.

Staff clearly recorded consent in the patients' records.

Nursing staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The overall compliance with MCA and DoLS training was 87%. Nurses were 93% compliant and additional clinical staff were 90% compliant. The safeguarding team provided MCA training through a mandatory safeguarding training programme. Training was provided on the trust intranet and through masterclasses.

Not all medical staff kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Medical staff were 42% compliant at the time of inspection. Plans were in place to improve this.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff could contact the trust wide mental health compliance team.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Several audits and reports were provided by the vulnerabilities, learning disabilities and safeguarding teams. Whilst none of these were specific to emergency care at Queen Elizabeth Hospital, they represented recent audits of MCA as it relates to vulnerable patient groups across the trust.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Policies were in place to support staff to identify and take appropriate action when it was necessary to seek authorisation to deprive a patient of their liberty. Staff could also access the adult safeguarding team for completing DoLS applications. Advice and support was also available from the local authorities (duty social workers) and the site leads. Approved DoLS forms and other resources were available on the trust intranet for staff.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff had access to an electronic system to raise DoLS applications with the local authority.

Urgent and emergency services

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, mostly 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.

The layout of the emergency department (ED) was conducive to maintaining privacy. Staff cared for patients in the 'majors' unit in individual self-contained cubicles. However, we observed a patient ambassador asking a patient why they had come to ED when they arrived. This conversation took place in the open and in front of other people.

Patients said staff treated them well and with kindness and our observations confirmed this. Feedback patients left included statements such as "I had a nurse, who was lovely and a great nurse, he talked me through everything that needed to happen and made me feel relaxed throughout, even though I wasn't able to take a relative with me to A&E" and "The nurse was so professional and real human; explained the process step by step. She identified the pain I was suffering and addressed the issue with the doctor within half an hour."

We observed staff asking patients for their consent before they touched them in any way, knocking or speaking before entering the particular space or room patients were in and making sure curtains, screens or doors were properly closed before attending to patient's needs. Patients we spoke with also confirmed this.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients living with mental health needs.

Staff offered distressed patients calm and kind reassurance. For example, we saw a patient living with mental health needs within the 'majors' department who was highly agitated and trying to leave the department. Staff spoke to them reassuringly, explained why this was not safe and encouraged them to return to their cubicle.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

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.

Urgent and emergency services

The chapel and prayer rooms were available for staff, patients and visitors who needed some time away from the ED. Members of the chaplaincy team also visited patients in the department, providing spiritual care as requested by patients and families.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff offered distressed patients calm and kind reassurance. Staff nursed patients in their own private cubicles.

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 saw positive feedback in letters and thank you cards which supported this.

Although staff were undoubtedly supportive and empathic, they told us they often felt guilty they could not provide the level of care and attention to patients as they would like to such as sitting and spending quality time with patients. Patients we spoke with were all positive about the care they received and understood the pressures staff clearly faced and they were doing their best.

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 followed the 'perfect patient information journey'. This was a seven-step process to embed high-quality patient information along care pathways, helping people get the right information at the right time.

Staff talked to patients in a way they could understand, using communication aids where necessary. For example, staff had access to communication cards.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. For example, patients and families were encouraged to complete the friends and family test.

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, so they met the needs of the local population. However, it was a challenge for staff to see and treat the number of patients presenting to the ED. Services put in place processes to accommodate the increase in patients such as a GP service and a walk-in service. However, ED staff felt there was a lack of a system wide approach to improve the service offered to patients which led to an increase in ambulance presentation of trauma patients to the Queen Elizabeth Hospital, without subsequent change in nursing and clinicians' numbers.

At the time of our inspection the rapid assessment and treatment (RAT) area was not being used for this purpose. Instead it had been re-purposed to support the resuscitation area.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients living with mental health problems, learning disabilities and dementia. Staff could access the rapid, assessment, interface and discharge (RAID) team, which was a specialist multidisciplinary mental health service, working within all acute hospitals in Birmingham for people over the age of 16.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could refer patients to specialist teams such as the vulnerabilities team. This included nurses with a specialist in learning disability, autism, mental health, and dementia and delirium. Staff allowed one visitor to be with a patient if they were considered vulnerable.

Alerts were on electronic records. This highlighted additional patient needs such as frequent attenders, patients living with mental health, learning disabilities and physical disabilities and patients with aggressive behaviours.

The service relieved pressure on other departments when they could treat patients in a day. For example, the GP service, overseen by the trust saw patients who would otherwise have been seen in ED. This helped to improve the time staff in ED had to provide care for acutely unwell patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. This helped hospital staff better understand the individual needs of people and provided them with information about a person to help enhance the care and support they receive whilst in an unfamiliar environment.

Staff followed processes such as the 'this is me' documents and patient passports.

The trust created 'Carers' packs' to give carers information about the 'carer coordinator service' and either enable staff to make a direct referral where applicable or allow the carer to refer themselves at a later date. This supported carers following a withdrawal of active engagement due to the COVID-19 pandemic and allowed carers to access support.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service did not have information leaflets available in languages spoken by the patients and local community. We saw a range of patient leaflets only in the English language. Staff we spoke with on the ambulatory care unit were not aware of leaflets being available in other languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. An *interpreting* service was available for both patients and staff. Staff could also use an i*nterpreting* telephone service.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Alternative diets were available for *cultural* or *religious* reasons.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff had access to resources to help them communicate with patients with additional or complex needs relating to dementia or learning disabilities, including a communication box. The box enabled patient to communicate effectively with staff until a relative could bring in any items they needed such as a hearing aid or spectacles.

Access and flow

People could not always access the service when they needed it or receive the right care promptly. 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; however, patients could not always access emergency services when needed or receive treatment within agreed timeframes and national targets. Local leaders were aware of how to escalate concerns. Staff told us that processes to manage this did not address the root causes such as high attendances.

As part of our inspection we reviewed nationally published emergency care waiting time statistics.

The median time from attendance at ED to initial assessment was five minutes across the trust for May 2021. This was better than the English average which was eight minutes for the same period.

The median time from triage to treatment as of May 2021, was 73 minutes across the trust. The England average at this time was 63 minutes. The expected standard is 60 minutes.

A national expectation at the time of inspection was that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. The operational standard was that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. The four-hour performance for March 2021 showed 62% of patients were seen within this timeframe. The trust wide figure for June 2021 was 61% of patients meeting the four-hour target. At this time, these were the worst four hour wait results in England.

The time taken for an ambulance crew to handover to ED staff is set at 15 minutes nationally as a target. As of May 2021, the performance for this standard was 31%. As previously stated, at the time of inspection the number of patients arriving at the department by ambulance was more than the department could hold. As a result, many patients were being held on ambulances until a space in ED was available. This significantly affected the ambulance handover times.

To support ambulance handover times, a hospital ambulance liaison officer (HALO) was based in ED and ensured efficient handovers took place between paramedics and the ED team. The HALO acted as an immediate point of contact between nurse coordinators and paramedics and meant these teams spent less time on handover, which resulted in a faster process for patients.

Number of waits for admission over 12 hours from decision to admit was low compared to the number of attendances. Data from the trust showed a trust total of five in the month of March 2021. This reduced to two in June 2021.

The site team led bed meetings four times each day, which were attended by the divisional director of operations, the clinical service manager, the divisional operations manager and the hospital ambulance liaison officer (HALO) in additional to senior staff from each specialty.

Urgent and emergency services

Managers and staff worked to make sure patients moved through the department as quickly as they could. For example, a navigation nurse improved patient flow through a variety of ways such as by re-directing patients to the most appropriate healthcare provider, assisting patients to find and register with a GP surgery, facilitating patient pathways, freeing clinical time by undertaking admin and clerical tasks from patient encounters, expediting discharge and stopping re-attendances.

The older people assessment and liaison team (OPAL) team met three times daily to review patients under their care, with a key focus on the prevention of out of hours discharges or transfers and the prevention of extended length of stay.

The percentage of patients who left ED before being seen between March and June 2021 ranged from 4% to 7%. This was slightly above the England average.

Managers and staff worked to make sure they started discharge planning as early as possible. The operations manager had oversight of hospital admissions, discharges and patient movement within the hospital to ensure ED patients were transferred and eventually discharged as soon as possible. However, staff said although they used a predictive modelling tool for four to six hours ahead, predictions were often not accurate.

Staff could not always move patients into other wards within the hospital due to a lack of bed space. This meant patients requiring ward-based care did not receive this in a timely manner.

Managers told us mental health pathway issues were getting worse. Staff said they could refer patients living with mental health needs to mental health nurses but there were delays when requesting mental capacity assessments to be completed due to demand. This had a negative effect in relation to identifying an exit strategy for these patients. Staff also experienced delays in getting approved mental health professionals (AMHPs) from social services to support discharges. Although the department had processes in place to address this such as a leader attending the fortnightly mental health meeting so they could highlight risks and issues, local leaders were limited in their influence as this was a national and system wide pressure.

Managers monitored patient transfers and followed national standards. The compliance with the Department of Health (DoH) standard that 95% of patients should be admitted, transferred and discharged within four hours of arrival to ED ranged from 50% to 64% between March 2021 and June 2021.

The monthly percentage of patients waiting more than four hours from decision to admit until being admitted between March 2021 and June 2021 ranged from 14% to 33%. This was slightly worse than the England average.

The monthly percentage of ambulance journeys with turnaround times over 30 mins from March 2021 to June 2021 ranged from 11% to 14%. The number of black breaches between March 2021 and June 2021 ranged from 99 to 21.

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.

Urgent and emergency services

The service clearly displayed information about how to raise a concern in patient areas. We saw complaint forms made available throughout the ED.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. From December 2020 to May 2021 the unit received 48 complaints. Themes were delay/failure clinical treatment, delay in department (such as tests and observations) staff attitude and communication (especially with patients).

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Staff would try to resolve a complaint before it escalated, however they knew how to advise patients of how to make a formal complaint if they wished to do so. Out of the 48 cases, one case was being led by another trust and therefore excluded from the data, 26 had met the deadline, eight had missed the deadline and 13 were still in date. The potential maximum performance if all still in date cases meet the deadline was projected to be 83%.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, the department carried out proactive work on 'perfect patient journey'. This was collaborative planning session between staff and patient representatives planned for 30 June 2021 to design a guide to the perfect patient journey though the ED. Trust quality improvement projects were also underway on discharge and communication as key feedback themes.

Staff could give examples of how they used patient feedback to improve daily practice. For example, following a complaint, managers asked a nurse asked to provide a piece of reflection to learn from not following trust post-falls procedure. An incident form was completed, and all ED staff were emailed to reiterate the importance of following this procedure.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. 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. Managers above local level were not visible in the service for patients and staff.

The service had a triumvirate senior leadership structure which included a clinical director, divisional head of nursing and a general manager who led the service.

Department leaders had the skills and ability to run the service. All staff we spoke with said they considered local department leadership and management teams to be accessible, responsive and supportive.

Although staff we spoke with said they considered local department leadership and management teams to be accessible, responsive and supportive, most staff said they rarely saw senior staff above matron level.

Urgent and emergency services

Staff felt disconnected from the leaders above local level. They felt they did not show an understanding of the pressures staff faced throughout department. For example, staff felt pressured into reintroducing corridor nursing.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Staff within ED felt this was not sustainable or achievable.

The trust strategy contained the overall direction of the trust. The ED strategy was to deliver 'Right person; Right place; Right time' through a number of transformation initiatives. These included primary care re-direct initiatives, direct ambulance referrals to specialties, streamlining ambulance patient offload processes in ED Majors, reducing timelines for patient assessment, treatment and referral and increasing ED capacity where feasible, including the use of non-cubicle patient care in EDs.

The clinical lead identified plans were to 'future proof' ambulatory care and to introduce oxygen and suction on the assessment unit.

Staff told us they did not feel engaged with the strategy for the department; and felt there was a disconnect between local staff experience and the understanding of divisional leadership and above.

Staff felt with the demand for emergency care steadily increasing year-on-year the situation of overcrowding, delays in ambulance handovers and risks associated with patient flow would only get worse unless there was a whole system approach to planning for and managing heightened demand.

Culture

Staff did not consistently feel supported and valued. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. Staff spoke of a 'blame culture where they could not always raise concerns without fear.

Whilst staff were continuing to work hard to ensure patients received the treatment and care they needed, patients having to wait longer to be treated in the department, or to be admitted to hospital, than normal had a negative effect on staff morale.

Increased demand and lack of support from the trust meant local leaders were very worried about their staffs' mental health and well-being. The department held cake competitions, photo competitions and other ways of helping keep morale up and to keep staff engaged with the department. Managers told us 'a happy and appreciated workforce will provide excellent patient care'. Staff told us they felt supported by local leaders, but not by the leadership above this level.

ED staff felt the executive team did not understand the pressures they experienced in the department. Staff told us they felt there was a blame culture coming from the trust to ED. For example, despite being promised they would not reintroduce corridor care at the time of our visit and local leaders were in discussion with trust around the safety of reintroducing this practice.

Consultants said staff were experiencing fatigue and they felt executive leaders were no longer interested in staff welfare.

Urgent and emergency services

We found evidence of strained relationships between some bands of staff, particularly nurses. However, all staff said they felt confident to raise concerns and address this directly with local leaders.

Junior doctors felt their practice was adequately supervised by an appropriately experienced clinician. They told us they had opportunities to learn how to provide safe care from observation of their seniors.

Consultants and registrars offered junior doctors' educational opportunities to assess their progress and provided feedback

The consultant sepsis lead fostered a positive working culture with colleagues in the department. Using personal communications, the consultant praised good performance in the sepsis standards audits and identified specific areas for improvements through discussion and collaborative learning.

To support staff throughout the pandemic, staff health and wellbeing hubs were located across the trust. This provided 'tea and coffee, rest and recovery'. Other information on wellbeing services was available.

Governance

Triumvirate and trust wide governance for the ED was structured and clear. However, this was not consistently seen at local level. Not all staff were clear about their roles and accountabilities.

The service had a clear governance structure. The trust had four sites, three of which had an ED and one a minor injuries unit. The MIU was closed for part of the COVID-19 pandemic to support other functions. These formed a wider ED group which had a triumvirate leadership overseeing this. The triumvirate leadership could escalate information to the board. Below the triumvirate leadership group, matrons and clinical leads oversaw the EDs at a local level.

Trust wide ED meetings were held to discuss issues, performance and risk. These included monthly quality and safety meetings for division three whereby representatives from all specialities and areas within division three would meet. ED specific clinical governance meetings were held monthly, as were emergency medicine directorate meetings.

We saw the agendas covered standard items such as risks, incidents, performance, staffing and complaints.

There were no meeting minutes to evidence locally held meetings for staff at the Queen Elizabeth site. We were told that staff meetings were held through on online teleconferencing, however the data to support this was not provided. As a result, we were not assured the local departmental risks and concerns were effectively escalated up to and including board level.

Following our inspection, consultants told us an ED consultant had been appointed governance lead to improve awareness and meet with the medical director once a week.

Not all staff were aware of the full extent of their roles and responsibilities. For example, not all staff involved in managing medicines were aware of their full responsibilities. Staff within the department did not all understand their role in overseeing patients held on ambulances.

Management of risk, issues and performance

Trust wide risks were recognised, and action plans created; not all local risks were escalated or acted upon. Patients were put at risk due to staff not always following trust wide processes. Staff reported a lack of oversight and collaborative working from trust wide leadership.

Urgent and emergency services

We reviewed the risk register for ED which combined risks for all four sites. We saw those relating to Queen Elizabeth Hospital Birmingham included insufficient numbers and skill mix for medical decision makers (doctors), emergency access delays due to large numbers of ambulance conveyed, and ambulatory patients attending, lack of onward beds for psychiatric patients, lack of skill mix in the nursing staff, problems with reviewing pathology reports, and requesting and managing radiology reports, and the impact of reconfiguring trauma services. All these risks spanned across more than one site; there were no risks specific to QEHB.

All the risks identified had mitigating actions attached.

Consultants identified the main risks in the ED as ambulance handover times, lack of middle grade doctors from six o clock in the evening, transfer of mental health patients to other services, uncoordinated IT systems and lack of guidance.

We found some local risks were not recognised outside of the department. For example, an audit conducted in 2021 around safe and secure handling on medicines highlighted a range of concerns to local leadership. However, there were no action plans put into place to address these risks. This meant we were not assured of the effectiveness of these audits to escalate risk and drive improvement.

Similarly, local audits reviewing safety checks on specialist equipment identified that staff were not compliant with trust processes and policies around this. Missing checks were identified and escalated to nurse in charge. However, managers told us following the inspection they had not reached the end of their current audit period and that they would develop action plans at the end of the audit cycle; rather than address immediate risks identified.

We raised concerns about the number of patients who waited on ambulances outside the department before a space inside the department became available. Although these patients remained the clinical responsibility of the trust ED staff, these staff did not have oversight of the patients under their clinical responsibility. Processes were in place to manage patients waiting on the back of ambulances due to lack of available space in ED. However, we found staff were not following these processes such as undertaking nursing and medical reviews or updating patient records. This meant patients on ambulances were at risk of deterioration or may have needed a specific clinical intervention which was not recognised in a timely matter. Whilst the trust reported they accepted the clinical responsibility of the patients, they reported there were arrangements in place with the NHS ambulance service for their staff to monitor and escalate patients to the relevant nurse as required. As part of the inspection we approached the NHS ambulance service who subsequently reported that no such formal process was in place with individual emergency departments.

Although local leaders had systems in place to monitor risk, issues and performance, staff in ED felt the trust held them solely responsible for risk, issues and performance measures in the department and did not appreciate these were part of a whole system. ED staff felt there was no collaborative working to optimise flow, which would lead to major improvements in patient and service user experience and outcomes.

Staff told us they felt pressured into reintroducing corridor care to patients which would reduce the risk around delays in bringing patients into the department. Staff felt this would heighten patient safety risks and promote unsafe practice. Staff reported concerns around difficulty in administering urgent intravenous antibiotics, lack of access to toilet facilities for patients, lack of privacy and dignity, and increased distress for patients, particularly those living with mental health problems. Staff felt this was an example of the trust addressing patient flow issues focussing on the ED rather than a trust wide issue.

Urgent and emergency services

The performance of ED was varied. For example, the trust performed well against the median time from attendance at ED to initial assessment (five minutes across the trust for May 2021. This was better than the English average which was eight minutes for the same period). However, the median time from triage to treatment as of May 2021, was 73 minutes across the trust which was worse than the England average of 63 minutes for the same time. The expected standard was 60 minutes.

Staff told us that they believed they were held accountable for the poor performance; and the department was not given enough resource to recover poor performance.

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 secure but not fully integrated. Data or notifications were consistently submitted to external organisations as required.

The service collected reliable data and analysed it. Leaders benchmarked their data against other trusts. This meant they had a systematic process in which current practice and care were compared to, and amended to attain, best practice and care

Staff used an electronic patient record system. This meant they could access key clinical and administrative data in one and had access to live data about timeliness of patient care. However, staff said IT systems were uncoordinated and there was a lack of guidance.

Performance measures provided feedback to staff on their actions and how those compared to those of their peers.

The service had effective arrangements to ensure that data or notifications were submitted to external bodies as required. During the inspection process, the trust sent data in a timely manner.

Engagement

Leaders and staff engaged with patients to plan and manage services. Public engagement was trust wide, rather than locally facilitated. Staff did not feel included or engaged with decisions made by senior leadership.

As a consequence of the pandemic, some patient engagement had been reduced or placed on hold in order to reduce the risk of contamination. For example, the patient experience team holding individual listening exercises with patients and their relatives/ carers in ED. Looking forward, local leaders said they had planned patient engagement groups in July 2021 to review and develop the 'perfect patient journey' process.

The ED received a total of 2,017 friends and family test (FFT) comments between January and April 2021. 63% of all comments received on the FFT were positive.

The Trust planned to run a 'goldfish bowl' workshop with patients who have used ED at QEHB, in order to better understand of thoughts and experiences of these patients.

We requested evidence of patient, staff and public engagement. Whilst we were given examples, many of these were trust wide or, in the case of staff, role specific such as work-related chat groups. We did not see evidence of active engagement from ED at Queen Elizabeth Hospital Birmingham with the public, especially with areas of the community who may not be able or willing to access the above routes.

There were some local initiatives to engage staff such as a 'you said we did' suggestions box in the staff room. This was used to gather ideas from the staff and either action them or explain why they could not do it.

Staff used a closed social media platform to share information and make requests such as shift swaps. Senior teams had a messaging application to communicate and immediately share information. This was especially relevant to the band 7 team to keep them up to date with changes and important issues.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

A project called 'Ask A & E' had been running since December 2020. As part of this project the navigation nurse identified patients who would be suitable to use an algorithm to determine if they needed to be seen in the emergency department or if they could be redirected to a GP appointment, pharmacy or for selfcare. This was an advisory service only and was ran by patient ambassadors who welcomed patients into the ED ambulatory area and took them through the registration and ask A&E process. They helped patients' book appointments if required with the GP services. This service was designed to help patients engage with the community-based services and avoid coming to the ED.

Surgery

Good ➔➔

Is the service safe?

Requires Improvement ➔

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

Mandatory training

The service provided mandatory training in key skills to all staff, however, did not make sure everyone completed it.

Not all staff were up-to-date with their mandatory training. Staff told us during the COVID-19 pandemic, mandatory training and attendance at training sessions had been suspended in an effort to meet the demands of the pandemic across the trust. The trust had 11 mandatory training modules which included manual handling, health and safety and infection prevention and control. Training records showed overall compliance with mandatory training across all staff groups within the service was 91%, which was above the trusts target of 90%. However, training compliance for medical staff was below the trust target at 79%. All clinical staff were also required to complete clinical life support training, for which training records showed overall compliance across all staff groups was 54%. Staff told us there were recovery plans in place, with a target of October 2021 for improved compliance.

The mandatory training was comprehensive and met the needs of patients and staff. Staff could access mandatory training in a variety of ways and included online eLearning and face-to-face socially distanced sessions as appropriate. Classroom sessions were cancelled in favour of virtual online learning during the peak of the pandemic, however face to face sessions had recently restarted.

Clinical staff completed training on recognising and responding to patients living with mental health needs, learning disabilities, autism and dementia. Staff attended a two day training programme which covered dementia, communication, activities of daily living (ADLS). The programme was suspended due to COVID-19 however it was due to recommence in September 2021.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers recognised mandatory training was a priority and had started to address this with staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, while the service provided training on how to recognise and report abuse, not all staff had completed required safeguarding training.

Not all staff received training specific for their role on how to recognise and report abuse. As with all mandatory training, safeguarding training had been postponed during the COVID-19 pandemic in an effort to meet the demands across the trust. Training records showed overall compliance across all staff groups for safeguarding children level 2 was 94%

which was above the trust target of 90%, however medical staff compliance was lower at 79%. Safeguarding children level 3 compliance for all staff groups fell below the trust target at 76%. Safeguarding adults level 3 was also below the trust target at 67%. Managers told us safeguarding training was a priority and safeguarding adults level 3 was a new requirement for nursing staff and healthcare assistance and a plan was in place to improve compliance.

Staff received Prevent awareness training which explained how to safeguard vulnerable people from being radicalised into supporting terrorism or being terrorists themselves. Training records showed overall compliance across all staff groups was 85%, which was below the trust target.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the trust's safeguarding processes and felt confident to raise and escalate safeguarding concerns. Staff were also able to provide examples of when they had escalated concerns and ways they worked together to protect patients from avoidable harm and abuse. The trust's safeguarding team were described as accessible and supportive.

Staff followed safe procedures for children visiting the ward. Due to COVID-19 restrictions, visitors to ward areas were limited in accordance with the trust's pandemic response. However, staff were aware of the risks to children when visiting.

Cleanliness, infection control and hygiene

The service did not always control infection risk, and equipment and premises were not always kept visibly clean. However, the service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection.

Not all ward areas were clean with some furnishing's visibly dirty and poorly maintained. On ward 728 we found vomit stains on a privacy curtain and surrounding windowsill. The patient said they had vomited two days before our inspection, and while the floor had been cleaned, the curtain had not been changed. We raised our concerns with staff; however, no action was taken, and another patient was moved into the side room with the curtain still visibly soiled. We raised our concerns again the following day and staff immediately changed the curtain. On ward 412 there was no regular cleaning of personal protective equipment (PPE) storage areas which were visibly dirty. A resuscitation trolley and a dressings trolley were also visibly dusty, despite staff saying they were checked daily. On the ambulatory care unit, trolleys were visibility covered in dust, a bright yellow stain covered the lid and sides of a drugs trolley on the surgical assessment unit.

Across the theatre department, all areas were visibly clean and tidy, and they maintained cleaning schedules within each theatre block. The department was compliant with national guidance on ventilation with laminar flow air changes in all theatres.

Staff did not always clean equipment after patient contact, and equipment was not always labelled to show when it was last cleaned. Across the service, the use of 'I am clean' labels were inconsistent, with them used on some wards, but not on others. Some labels showed equipment had been cleaned recently, while others were dated May 2021. On ward 412, we found a commode with a label to say it was clean dated 19 May 2021, however it was visibly dirty with urine and hair. We also found a bedpan which was covered in faeces, and the bladder scan was visibly very dirty with a label to say it was cleaned 24 May 2021.

Surgery

Clinical waste was not always appropriately stored or disposed of in all clinical areas. On ward 727 and the surgical assessment unit (SAU) we found sharps bins which were overfilled and unemptied. On ward 408 and SAU, the contents of two sharps bins were sticking out of the top and posed a risk of needlestick injury. We also found a bottle labelled 'harmful' on ward 412 which was not stored securely. On SAU the general and clinical waste room door was left propped open, mitigating the combination lock to prevent unauthorised access. However, there was correct segregation of clinical and non-clinical waste into different coloured bags. There was a chemical spill kit in place in theatres. Specimens were stored in line with trust policy, and theatre staff labelled and documented specimens before transfer to the pathology department.

The service generally performed well in hand hygiene audits. Hand hygiene audits showed between March and May 2021, average hand hygiene compliance across surgical wards was 90.3%. While no wards had reached the trust target of 100%, the service had plans in place to improve compliance. Ward managers carried out weekly hand hygiene audits if they did not achieve 100% compliance, and daily audits were advised for those areas below 90%. Virtual resources were sent out to ward managers following world hand hygiene awareness day in April to share with staff.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff, patients and visitors complied with the trust's infection, prevention and control (IPC) processes, including additional COVID-19 precautions which were in effect across the service. Face masks and alcohol hand gel were freely available, including at the main hospital and on every ward. Staff complied with social distancing precautions when required. Information for staff and visitors regarding IPC and COVID-19 precautions was displayed across the service, including at entrances to wards. Personal protective equipment (PPE) such as gloves and disposable aprons were used in accordance with the trust's infection control policy.

Screening for MRSA (Methicillin resistant Staphylococcus aureus), Clostridioides difficile (commonly known as C. difficile) was completed for elective patients during their pre-operative assessment before surgery and 28 days post admission. Patients who received a positive result were prescribed and provided a course of treatment before they could be admitted for surgery. All patients who were admitted as emergency admissions to surgical wards were also screened for MRSA and appropriate measures taken if positive. Audits of MRSA screening showed between March and May 2021, 95% of elective and 90% of emergency patients were screened. However, there were large variations in screening compliance. On ward 410 only 50% of elective patients were screened in March 2021, and on wards 408 and 410 the average compliance of emergency MRSA screening was 81% and 76% respectively.

While screening rates of MRSA were variable, between June 2020 and June 2021 the trust reported one hospital acquired infection on surgical wards. During the same period, they reported 23 hospital acquired Clostridioides difficile infections. The service had action plans in place to reduce incidences of hospital acquired infections, which included weekly environment audits, daily cleaning of mattresses and sharing of good practice.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score (NEWS) when performing observations. Clinical observations such as blood pressure, heart rate, and respirations were recorded electronically and contributed to a total score. The NEWS score was calculated automatically and if a threshold was reached, notifications for escalation were sent to clinicians and critical care outreach teams. Patients with a NEWS of three or more were automatically screened for sepsis. Patients admitted or transferred to a surgical ward should have observations taken and a pain assessment completed within six hours.

Surgery

Performance dashboards showed between April and June 2021, this was completed for 93.3% of patients, with some wards less than 90% compliant. However, patients who were taken to and remained in theatre for a long time may be marked as missed reducing the overall compliance. A full set of observations were taken every 12 hours, and performance dashboards showed between April and June 2021, NEWS scores had been recorded for 99% of patients admitted to surgical wards.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Comprehensive risk assessments were completed electronically for all patients following admission to surgical wards. Nursing staff used nationally recognised tools to assess patient's risk of developing, for example, pressure ulcers, nutritional risks, falls, and risks associated with moving and handling. These were reviewed regularly, and if a patient's condition changed or following an incident, a new risk assessment was completed. Patients identified at risk were placed on care plans and were monitored more frequently by staff to reduce the risk of harm.

However, performance dashboards showed risk assessments were not always completed for falls and pressure ulcers. On two wards we reviewed, between May and July 2021 completion of falls and pressure ulcer risk assessments was below 85%. Staff said action plans on how to improve completeness of observations were in place and senior nurses monitored dashboards daily.

Staff assessed most patients to identify the risk of venous thromboembolism (VTE) within 24 hours of admission. Patients were also reassessed if their clinical condition changed. Clinical staff documented initial VTE assessments on admission and all patients had VTE prophylaxis (preventative treatment) prescribed. Audits showed in May 2021, one of nine patients reviewed did not have a VTE assessment completed within 24 hours of admission. An action plan to improve VTE compliance was in place as part of the trusts VTE quality improvement project.

Staff used the World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. Use of the WHO checklist was well embedded, respected by all staff grades, and was completed comprehensively. All staff concentrated during each stage of the checklist and were engaged with the process.

The service had 24-hour access to mental health liaison and specialist mental health support. This included the arrangement of psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff said they were able to get advice and support when 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. Nursing staff led daily handovers between shifts and provided an update on the plan of care for each patient. This included patients due for discharge and patients at risk of deterioration or who required extra monitoring. Planned diagnostic tests and procedures were also shared.

Nurse staffing

The service had 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, the number of nurses and healthcare assistants did not always match planned numbers.

The service had enough nursing and support staff to keep patients safe, however the number of nurses and healthcare assistants did not always match planned numbers. Staffing data showed between April and June 2021, the average nursing fill rate within surgery was 78%. Night shifts reported higher average fill rates of 84%. Actual staffing levels

decreased every month from 82% in April to 74% in June 2021. For healthcare assistants (HCA), the fill rate was 124%, with night shifts also reporting higher fill rates of 146% on average. Managers told us the HCA staffing was above 100% for both day and night shifts to assist in mitigating the unfilled nursing shifts and was part of the service's workforce plan. They also said shift fill rates were impacted by staff absence related to COVID-19, including sickness absence, shielding, self-isolation and children care commitments.

The ward manager could adjust staffing levels daily according to the needs of patients. Managers told us where additional staff were required due to an increase in acuity or specific needs of patients this would be done. Band 7 nurses reviewed staffing levels daily and were able to flex staff to accommodate each day. Escalation processes were in place to mitigate the impact of when planned staffing levels were not achieved.

The service had low vacancy rates. Staffing data showed for May 2021, the nursing vacancy rate was 6%. For HCA's the number in post exceeded the establishment, with the service oversubscribed by 14%.

The service had low turnover rates. Despite the COVID-19 pandemic, the turnover rates for nursing staff had not increased. Staffing data showed between January 2020 to January 2021, the trust wide turnover rate was 8%, within surgery, the turnover rate was 2.3% for nursing staff.

The service had low and reducing sickness rates. Managers told us while vacancies within the surgery service were low, there were high sickness rates. Staffing data showed between March 2021 and May 2021, the average sickness rate for nursing staff was 4%. The rate was reducing with sickness recorded as 3% in May, a reduction from 6% in March. Managers were aware of the potential for an increase over the next few months due to burn out or mental ill health as a result of the pandemic.

The service had reducing rates of bank and agency nurses. Staffing data showed between March 2021 and May 2021, shifts covered by agency staff reduced from 40 to one. Managers told us they had good support from the nurse bank who helped to cover the shortfall with open vacancies.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Staff, including bank and agency said they received a comprehensive and structured induction when they commenced work at the trust.

Medical staffing

The service 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, the number of medical staff did not always match planned numbers.

The service had enough medical staff to keep patients safe, however the number of medical staff did not always match planned numbers. Staffing data showed between April and June 2021, the average medical fill rate within surgery was 82%. Night shifts reported higher fill rates of 99% on average. Actual staffing levels decreased every month from 87% in April to 74% in June 2021. Managers told us shift fill rates were impacted by staff absence related to COVID-19, including sickness absence, shielding, self-isolation and children care commitments.

The service had low vacancy rates for medical staff. Staffing data showed for May 2021, the medical staff vacancy rate was 5%. Managers confirmed low vacancy rates and told us they had a process in place for recruiting to vacant posts, with cover provided by locum staff in the interim.

The service had low turnover rates for medical staff. Within surgery, the turnover rate was 6% for medical staff. Some junior doctors we spoke to said they enjoyed working within the service and hoped to gain employment at the trust in the future.

Sickness rates for medical staff were low. Staffing data showed between March 2021 and May 2021, the average sickness rate for medical staff was 1%. This was low compared with other staff groups, with the highest rate of sickness recorded in April at 4% within cardiac surgery. The rate had remained the same with sickness recorded as 1% for all three consecutive months. Managers were aware of the potential for an increase over the next few months due to burn out or mental ill health as a result of the pandemic.

The service had low and reducing rates of bank and locum staff. Staffing data showed between March 2021 and May 2021, shifts covered by locum staff increased slightly from 106 to 125. Data showed between March 2021 and May 2021, bank usage had reduced from 414 shifts to 253.

Managers could access locums when they needed additional medical staff and made sure they had a full induction to the service before they started work. Training records showed overall compliance with corporate and local inductions for medical staff within the service was 90% and 93% respectively. This was above the trust target of 90% compliance.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Medical staff told us there was a good mix of skill within their teams.

The service always had a consultant on call during evenings and weekends. Staff told us there were always medical staff available and staffing data confirmed there were two consultants on call out of hours.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.

Patient notes were comprehensive and all staff could access them easily. Staff used both electronic and paper records across both theatres and the wards. Daily care records completed on the ward such as pain scores and blood pressure were complete. Staff also used national assessment tools such as national early warning scores (NEWS), the malnutrition universal screen tool (MUST), and risk assessments for venous thrombo-embolism (VTE) which were comprehensive and up to date. All records were legible, and the entries, dated, timed, signed and the designation of the person making the entry was identified. Staff recorded preoperative assessments on a standardised form based on national guidance.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. While paper records were generally stored away from public view in lockable trolleys, two sets of patient records on ambulatory care and two diagnostic reports on the surgical assessment unit were left unattended and in view of patients and visitors. We raised our concerns with ward staff who immediately ensured they were stored correctly and securely. Patient records were also stored electronically, with computer access password protected. Staff used individual log-ins to gain access to secure information. However, in most areas across the service, computers screens were left unlocked. We raised our concerns with staff who said no patient information was accessible without additional log-in details.

Surgery

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored correctly.

Staff followed systems and processes when safely prescribing, administering and recording medicines. Staff administered medicines safely by checking patient's identification and allergies, providing appropriate support and recording administration on the trust's electronic prescribing and medicines administration (EMPA) system. Staff ensured all medicines were administered as appropriate, with medicines rarely recorded in the patient's medication records as not being available to administer.

Medicines were not always stored correctly. While medicines were generally stored securely in locked cupboards and fridges with controlled access, we found medicines storage trolleys on two wards were unlocked and left unattended. We raised our concerns with ward staff who immediately secured the storage trolleys. Storage trolleys and cupboards were tidy, and medicines were available when required.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Pharmacists regularly reviewed records including medicines reconciliation and 'when required' treatments. During the pharmacy huddle, reviews on each ward were tracked to ensure staff were able to cover any gaps.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff prescribed medicines correctly and safely using the trust's EPMA to record medicines administration. However, while medicines fridge temperatures were generally monitored and actions taken if they were out of range, staff on two wards were unable to provide evidence they had taken action when fridge temperatures were found to be out of range.

Staff followed current national practice to check patients had the correct medicines. Medicines reconciliation was completed and recorded appropriately. We saw VTE assessments were completed leading to the prescribing of anticoagulants in line with guidance. Where patients were discharged on anticoagulants and would require community assistance in their administration, this was documented.

Staff advised patients on their medicines and specialist teams worked with ward staff to ensure patients were prepared for discharge, including being confident in their medicines needs.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff were aware of their responsibilities in managing safety alerts. Information was shared and actions taken where necessary. Medicines incidents and near misses were reported and investigated on the ward. Learning following incidents was generally shared with staff, with copies of alerts and safety information shared through email and put up on ward notice boards. However, staff were unaware of recent serious incidents regarding VTE assessments which had occurred across surgical wards. Staff understood the need to ensure both initial and subsequent VTE assessments were completed to ensure medicines were given as appropriate. The pharmacy team were aware of the serious incidents and were continuing to review VTE assessments.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. While we did not see any evidence of medicines being used to control patient behaviour during our inspection, pharmacy staff told us they would highlight where medicines were being used for behaviour management and would request medical review. Ward staff were aware of trust policies regarding this process and worked well with the pharmacy team.

Surgery

Antibiotic prescribing was in line with national guidance and staff followed good practice in prescribing.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored. However, while managers investigated incidents and shared lessons learned with the whole team, they were not shared with the wider service.

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.Staff understood their responsibilities to raise concerns, and there was a positive culture of reporting incidents. Staff across the service described the process for reporting incidents and gave examples of when they had done so. Staff were aware of what constituted an incident, and the types of issues they should report and record as incidents. Staff said managers encouraged them to report incidents and supported to do so.

The service reported 14 never events between June 2019 and May 2021 which involved surgical services. Two never events occurred on surgical wards, while nine occurred across the theatre department. The remaining three occurred in other areas. Of the nine that occurred in theatres, the two themes identified were retained foreign object and wrong site surgery. Incident reports we reviewed showed poor WHO checklist compliance was the biggest contributing factor across the never events in theatre. While there were similarities between the incidents, they occurred across different specialities and surgical teams.

Managers shared learning about never events with their staff, however staff were generally unaware of never events that happened across the trust. Staff across the theatre department were aware of the nine never events and said learning had been shared. This included the focus on ensuring compliance with the WHO checklist which was a key failing across the never events. However, on surgical wards staff were unaware of any recent never events, including those in theatre and across the trust such as in medicine.

Staff reported serious incidents clearly and in line with trust policy. Between April 2020 and May 2021, 71 serious incidents (SIs) were reported under the STEIS (strategic executive information system) framework in surgery. Most of these incidents were related to infection control, with 23 of these COVID-19 specific.

Staff generally understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. While some staff were unfamiliar with the terminology used to describe duty of candour, they were aware of their responsibility to be open and honest with patients when things went wrong. Senior staff were able to describe the process of undertaking duty of candour and gave examples of when they had done so. We saw duty of candour being applied effectively by a nurse in charge following a recent fall. From investigations, we saw the service had applied duty of candour following serious incidents.

Staff received feedback from investigation of incidents and met to discuss and look at improvements to patient care. However, not all staff were aware of incidents external to the service. While staff could give examples of incidents which had occurred on the ward, awareness of incidents which had happened on other wards and across the trust was variable. Learning from incidents was shared through ward and department communications including email and team meetings. Ward staff attended daily handovers where any recent incidents were discussed and learning shared. Some incidents were also shared as part of the trust wide email bulletin.

Surgery

There was evidence changes had been made as a result of feedback. Following a serious incident in the renal theatre, one recommendation was to relocate specific fluids to a designated theatre transplantation fridge due to poor stock control processes. This reduced the risk of death or severe harm from administration of an incorrect fluid as detailed in a patient safety alert.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed five serious incident reports involving surgical services at the trust and found these had been fully investigated and looked at the causes of the incident. They identified learning opportunities and had action plans in place with staff members identified as the lead for each action. There was evidence of duty of candour being implemented.

Is the service effective?

Good 

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

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 up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were up to date and followed guidance from the National Institute for Health and Care Excellence (NICE) and other professional associations. For example, pre-operative patients were assessed in accordance with NICE NG45 'Routine pre-operative tests for elective surgery' (2016). This included MRSA screening and blood tests.

The service monitored compliance against national guidance and policies and took steps to improve compliance where further actions were identified. A bi-annual NICE guidance report showed the trust was 66% compliant in March 2021, compared with 47% in August 2020.

Patients' clinical conditions and outcomes were assessed using nationally recognised assessment tools and audits. This included the national early warning score (NEWS) for monitoring clinical observations. Best practice information was displayed in staff areas such as treatment and staff rooms. This included hydration and fluid balance, pressure ulcer prevention, and falls prevention and management. Audits were carried out on wards to monitor processes to keep patients safe. These included audits of NEWS, pain management, and pressure ulcers. Results of audits were displayed as part of the services' performance dashboards.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff were aware of the Act and would follow the Code of Practice. There were no patients subject to the Mental Health Act during our inspection.

At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers when required.

Surgery

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 followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs. However, staff did not always assess nutrition and hydration needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition, however this was not always completed. Patient's nutrition and hydration needs were assessed on admission, monitored, and recorded using the nationally recognised Malnutrition Universal Screening Tool (MUST). Where assessments identified risk, staff completed fluid and nutrition charts and additional nutritional support was requested. High risk patients were referred to a dietitian for review. Nutritional risk assessments we reviewed were all completed appropriately and there was evidence of escalation. However, performance dashboards showed risk assessments were not always completed. On two wards we reviewed, between May and July 2021 completion of MUST risk assessments was below 80%.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used fluid balance charts to monitor patients' fluid intake and output.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Where the MUST risk assessment identified a patient was at risk or if a patient had a specific dietary requirement, staff referred patients to dietitians for continued support and advice. Care plans for these patients were also put in place to support their needs.

Where patients were identified to have swallowing difficulties, staff referred patients to the speech and language therapists who would provide support. Patients who required additional physical support with their meals or were on food charts had their meals delivered to them on a red tray. This aided swift identification of those who required assistance and prevented food from going cold.

A wide range of 'healthy' menu choices were available for all meals and patients could choose from a variety of foods, including foods which met cultural and religious requirements.

Patients with nausea or vomiting were prescribed appropriate medication. Patients had jugs of water within reach. These were regularly refilled. Spill cups were provided to help patients drink independently. Intravenous fluids were prescribed when necessary.

Patients waiting to have surgery were not left nil by mouth for long periods. Before surgery patients were kept 'nil by mouth' and fasted in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Elective patients were given clear instructions about fasting before admission. Patients fasting before surgery were monitored by staff on the admissions lounge and were given food or water as per advice of theatre staff if there were delays in taking the patient to theatre.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, however, did not always give pain relief in a timely way. They supported those unable to communicate using suitable assessment tools 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 assessed patients for pain during six hourly routine observations using a numerical scoring tool. Staff said they would observe patients' facial expressions, body language, and a change in behaviour if they were unable to communicate with them. Staff also had access to tools to help assess the level of pain in patients who could not express this verbally.

Performance dashboards showed between March and June 2021, six hourly observations (including pain scores) were completed for 93.4% of patients, with some wards less than 90% compliant. However, patients who were taken to and remained in theatre for a long time may be marked as missed reducing the overall compliance.

Patients generally received pain relief soon after requesting it. While most patients received pain relief promptly, two patients said they waited for over three hours during the night for pain relief. This was due to staff attending to a deteriorating patient and limited staffing on the ward.

Staff prescribed, administered and recorded pain relief accurately. Following surgery, recovery staff monitored patient's pain well and administrated appropriate analgesia promptly. After returning to the ward, patients were prescribed and given a range of analgesic medicines. For patients who required additional support and advice to manage their pain, staff had access to a pain team. Staff said they were accessible and supportive.

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 participated in relevant national clinical audits, which included the elective surgery Patient Recorded Outcomes (PROMs) programme and the National Emergency Laparotomy Audit (NELA). PROMs and other national audits were reviewed by the clinical lead for the relevant speciality and the service acted to improve services and made recommendations following analysis.

Outcomes for patients were mixed and did not always met expectations, such as national standards. The trust participated in the National Emergency Laparotomy Audit (NELA). Results from the most recent audit showed the service performed worse than expected. The service did not meet the national standard for five of the six measures. While five of the six measures had deteriorated compared with the previous year, one measure had improved. The proportion of cases with access to theatres within clinically appropriate time frames had improved from 65.5% to 78%. The worst performing measure was proportion of patients with a high risk of death (5% or more) who had a consultant surgeon and anaesthetist present at the time of their operation at 64.5%.

Staff told us the NELA audit was an ongoing process where feedback on potential improvements was received after each quarterly submission. Current unpublished audit data showed improvements over the September 2020 submission. The most recent submission for quarter three 2020/21 due for publication shows the proportion of patients with a high risk of death (5% or more) who had a consultant surgeon and anaesthetist present at the time of their operation also improved from 64.5% to 84%, above the national average. Staff said the portion of cases with access to theatres within clinically appropriate time scales could be improved, however performance was worse than average due to competing theatre specialities at Queen Elizabeth Hospital Birmingham.

The trust also participated in the National Hip Fracture Database Audit. Audit results showed the service did not meet the national standard for three of the four measures, however performance was either similar or slightly higher than the England average.

Managers and staff used the results to improve patients' outcomes. Information shared by the service showed audit outcomes and research conducted locally fed back into pathways to improve the patient experience and overall outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. While several audits were paused or abandoned during the last 12 months to enable the trust to respond to the COVID-19 pandemic, a large number were carried out. Each speciality had an annual audit programme, which were reviewed as part of quarterly governance meetings and local departmental meetings. The trust's clinical quality monitoring group had oversight of all audits, and met on a six-monthly basis to review compliance against speciality audit programmes and mandatory national audit participation. Speciality audit reports we reviewed were standardised and included recommendations and actions plans detailing areas for improvement.

Managers shared and made sure staff understood information from the audits. Audits and quality improvement projects and associated outcomes discussed regularly at department and speciality meetings. Staff told us audits were shared and they were given the opportunity to contribute and suggest how they could improve outcomes for patients.

Improvement was checked and monitored. All staff understood the audit process. Audits were and repeated following successful implementation of improvement measures and following a period of embedding to check if they had been successful.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff, including agency, a full induction tailored to their role before they started work. Staff said they received a comprehensive and structured induction when they commenced work at the trust. This included a trust wide induction and local induction. Training records showed overall compliance with corporate and local inductions across all staff groups within the service was 97.4% and 97.5% respectively. Nursing staff who were new to clinical areas had a two-week supernumerary period as part of their induction. This allowed them to familiarise themselves with the environment, processes, policies and procedures. During this time staff worked with specialist nurses to support in the development of new skills.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff records showed appraisal rates for nursing staff were 80.3% and 68.9% for allied health professionals. Managers told us they had started to book nursing and AHP staff in for their appraisals and had plans in place to improve rates. Across all surgical specialities, 49.7% of medical staff had received an appraisal. The trust suspended the medical appraisal process during the COVID-19 pandemic, in an effort to meet the demands of the pandemic across the trust, which was re-started in April 2021. Non-trainee medical staff were given a six-month grace period from their last appraisal due date to attend their annual appraisal. In March 2020, the completion rate pre-pandemic for medical appraisals was 88.1% with plans in place to reach this figure by December 2021.

The clinical educators supported the learning and development needs of staff. In theatres, professional development officers and educational team had re-started training following a pause due to the pandemic. A programme had been developed to ensure skills gained during redeployments were maintained and could be used in the event of another peak in COVID-19 cases.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Face to face team meetings had been cancelled in response to the COVID-19 pandemic, however some continued to be held virtually. The physiotherapy team continued to have regular virtual team meetings and said they worked well.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. The service had a range of specialist nurses and other professionals to provide guidance, education and support for staff in the clinical areas.

Managers identified poor staff performance promptly and supported staff to improve. Managers gave examples of when they had taken appropriate action in response to poor performance.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, MDT meetings did not happen on all wards.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. However, this did not happen on all wards. Nurses and members of the multidisciplinary team (MDT) regularly attended daily huddles on some wards. During huddles, staff worked together to ensure the best outcome for patients and discussed required levels of support. Patient care was planned in several specialities through MDT meetings. On wards where there was no regular input or MDT meeting, staff said they were not always aware of the holistic treatment plan for patients.

Across the service, there were effective and positive working relationships between doctors and nurses and wider MDT members. Ward rounds were performed by both consultants and registrars. Medical and nursing staff were involved, together with physiotherapists, and/or occupational therapists. Pharmacy staff attended ward rounds for advice. There was good multidisciplinary working between all members of the MDT. Consultants felt they had good support with difficult cases from colleagues and could arrange additional MDT meetings to discuss complex cases.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff could access dietitians, occupational therapists, safeguarding teams and the critical care outreach team who were able to provide support and advice when required. Staff told us how they had accommodated patients before surgery to alleviate their fears and worries enabling patients to attend their procedure.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff said they were able to get quick and efficient mental health support for patients.

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 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. Staff clearly recorded consent in the patients' records. Patient records we reviewed had good documentation of consent, which included obtaining formal consent for procedures and surgical intervention. Staff understood the principles of different forms of consent. They took verbal consent, when a patient verbally agreed to treatment after they had received information, and implied consent, when

they assumed permission to do something from the patient's actions. They always checked with patients before they undertook tasks such as administering medicines or taking bloods, regardless of the type of consent obtained. Local audits of the consent process were carried out within specialities including lower gastrointestinal surgery and liver transplant. Specialities had plans in place to improve, based on recommendations following these audits.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system they could all update.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. This included care passports and 'this is me' documentation to inform staff of the patient's wishes.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Training records showed overall compliance with MCA and DoLS training across all staff groups was 92%, which was above the trust target of 90%. However, training compliance for medical staff was below the trust target, at 84%. Staff told us there were recovery plans in place, with a target of October 2021 for improved compliance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Medical staff supported patients to make decisions in line with relevant legislation and guidance. They were aware of MCA and DoLS requirements and said they had received training. Nursing staff were aware of processes of how to support medical staff to assess and record decisions about care and treatment if patients lacked mental capacity and how to make 'best interest' decisions.

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. Where a Deprivation of Liberty Safeguards had been applied for, managers were aware and were able to talk confidently about the reasons behind them. They supported staff to ensure measures taken to safeguard patients were correctly completed and measures taken to safeguard patients were appropriate. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The trust audited the application of MCA and DoLS and made changes based on areas for improvement. This included myths and misconceptions posters about MCA and DoLS, and a series of webinars to raise the importance of decision specific mental capacity assessments.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew how to access policies and guidance around MCA and DoLS on the intranet. There were link nurses for MCA and staff said they were accessible and supportive.

Is the service well-led?

Good 

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

Surgery

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Surgical divisional leaders told us they had a good working relationship with each other and were each dedicated to their role and responsibilities. Divisional leaders understood the challenges they faced around quality and sustainability of services, including bed capacity and staffing issues.

Local leadership was provided by matrons and ward managers. Staff were positive about their local leadership team and said they were visible and supportive. Matrons visited their clinical areas every day to ensure they were visible and accessible to staff who required support. Senior leaders including deputy directors of nursing aimed to visit clinical areas at least once a week.

Staff across the theatre department said the leadership team were all accessible, transparent, supportive and effective. Theatre staff also said they had good support from senior clinicians who were immediately accessible and always happy to advise.

Most junior doctors told us they felt well supported by their registrars and consultants, who were approachable and accessible including out of hours. They told us the leadership team had managed the redeployments in response to the COVID-19 pandemic well with high levels of supervision due to the increased presence of registrars and meant there was minimal disruption to their learning opportunities. Junior doctors also said consultants were more active, visible and accessible during the day. Some junior doctors told us they had such positive experiences at the location that they were keen to stay on past their junior doctor rotations.

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 recovery following the pandemic, as well as sustainability of services Leaders and staff understood and knew how to apply them and monitor progress.

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: collaborative, honest, accountable, innovative, and respectful. Staff had previously been given the opportunity to be involved in developing the trust's vision and values.

The trust implemented a new strategy in 2019 with nine key aims for how they wanted to achieve their vision 'to build healthier lives'. Across the surgical service this included developing multi-site delivery of activity, working more with partner organisations such as dedicated orthopaedic providers, and making better use of resources. However, as a result of the COVID-19 pandemic, staff focused on making rapid changes in response to the demands on the service. During summer/autumn 2020, the service focused on recovery and restoring services, alongside the increasing demand and pressures from COVID-19.

In response to the focus on COVID-19 restoration and recovery of services, all divisions and specialities had been asked to outline priorities and plan for the next six months. This would be a rolling process developed per month per division. Staff were aware of the overarching priority to restore the services and catch up on the increasing backlog of patients.

Surgery

Culture

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.

Most staff across the service said they felt supported, valued and respected their colleagues and managers. Staff were aware of the challenges of the COVID-19 pandemic, and managers understood the impact this had on staff wellbeing and morale. Managers told us staff across the service were tired and feeling drained, with some staff close to burn out. Staff were aware of the well-being support available across the trust and said local managers were supportive of them accessing these. Well-being initiatives available included counselling services, the employee assistance programme, a helpline for Filipino staff, mental health first aid and well-being hub.

Staff told us they were proud to work for the trust and had a common sense of purpose. There was a culture of collective responsibility between teams and services, and we saw positive and supportive interactions between all staff. While staff said the service was patient centred and they were committed to high quality care, leaders were aware of the changes that had been required in responding to the COVID-19 pandemic had impacted on service delivery and staff morale.

Openness and honesty were encouraged at all levels, and staff said they were able to discuss and escalate concerns without fear. Staff were aware of and understood the role of the Freedom to Speak Up Guardian. Managers described having an 'open-door' approach, which was confirmed by staff who said they could raise concerns without fear of reprisal. When something went wrong, patients received a sincere apology and were told about any actions to prevent something similar happening in the future. Staff told us the service operated in an open, friendly and inclusive manner and there was a 'no-blame' approach with respect to complaints and incidents.

Staff said equality and diversity was promoted, and those with particular protected characteristics were treated equitably.

Governance

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders generally operated effective governance processes, throughout the service and with partner organisations. However, audits did not always accurately reflect circumstances across some clinical areas.

There was an effective governance framework in place which included regular quality and safety governance meetings used to demonstrate effectiveness and progress across the service. There was clear accountability for managing risk and making service improvements, and staff understood their roles and what they were accountable for. Each division reported key quality, safety and performance metrics in quarterly clinical governance and patient safety reports. As part of the governance framework, the trust planned to implement the model at speciality level however this was delayed due to the COVID-19 pandemic and operational pressures. Speciality governance meeting minutes we reviewed showed performance and safety issues were clearly discussed and any actions required to improve the service were identified appropriately. However, during our inspection we identified clinical areas which were visibly dirty, equipment was not always clean, and clinical waste was not always stored or disposed of appropriately. This did not reflect environmental audits we reviewed, with actions only taken following escalation by the inspection team

Surgery

Regular ward meetings were cancelled due to social distancing measures in response to the COVID-19 pandemic. Some areas had started to reschedule team meetings however there were challenges around this due to the ongoing restrictions in place. Nursing staff attended ward safety huddles where key messages and information relating to specific patient issues were shared. Staff were positive about the team briefs and newsletters and said there was a good level of communication from local managers and senior leaders.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. As the surgical service crossed four of the trust's divisions, there was no surgical divisional risk register. Instead each speciality maintained its own risk register, which included local ward level risks. Risk registers we reviewed were standardised across all specialities and defined the severity and likelihood of risks causing harm to patients or staff. They also documented the control measures in place to reduce the risk. The top risks on speciality risk registers were included and discussed during regular divisional quality and safety meetings. Minutes from these meetings showed the level of risk was routinely discussed and changed if necessary. However, while new and existing high level risks were reviewed regularly, there was little evidence of low level risks being reviewed.

Across the surgical service, the top risks included waiting lists with an increasing backlog of surgical patients, and staffing issues. The risks that were described accurately reflected the concerns described by staff across the service. All risks were recorded electronically to ensure the governance team had full oversight. Risks were discussed and agreed at the divisional meetings before a risk was accepted onto the register.

Locally, ward managers and matrons monitored risks, issues and performance through their dashboards. The performance dashboards used by nursing staff held information against a number of metrics including clinical risk assessments and outcomes. Each metric had a 90% compliance target. Where areas failed to meet this target, this was reviewed at the governance meetings.

During quality and safety governance meetings, incidents and complaints were discussed. Complaints were also discussed at daily safety huddles and regular team meetings. Staff told us that they received feedback from incidents and complaints in team meetings and safety briefings.

The service monitored compliance against national guidance and policies and took steps to improve compliance where further actions were identified. For example, audits had been undertaken to ensure compliance with WHO checklist completion in line with National Patient Safety Agency (NPSA) guidelines and trust policy.

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.

The divisional and local leaders took action to make improvements in the running of the surgical service. They had regular meetings where learning was discussed, including quality and governance meetings and daily safety huddles.

Many changes were made in response to the COVID-19 pandemic to both patient pathways and ward locations to improve patient care and safety.

Surgery

Several quality improvement (QI) projects were also implemented across the trust, which impacted on surgical services. These were aimed at consistency and efficacy of ward rounds, consistency of MDT meeting, and the safe delivery of care during invasive procedures.

Cancer services

Good

Is the service safe?

Good

We rated safe as good.

Mandatory training

The service did not always provide mandatory training for medical staff in key skills.

Some staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Staff accessed their mandatory training by a mixture of e-learning and practical sessions and received mandatory training in a variety of topics.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Overall, from data provided by the trust on 18 June 2021, the compliance rates for staff working within the cancer services based at Queen Elizabeth Hospital was over 90% except for medical staff which was 79%.

Medical staff we spoke with from various profession and levels told us they were not always able to attend training or complete their mandatory training within the dedicated time due to staff shortages.

All staff had completed their two yearly mandatory practical fire safety training and yearly e-learning fire safety.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, not all medical staff had completed their safeguarding training.

Staff within the cancer services received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw on display throughout the department a safeguarding algorithm to provide a step by step guidance.

Overall, from data provided by the trust on 18 June 2021, most staff groups met the trust target of 90% for the required levels of safeguarding training, however, medical staff compliance was 60% for level two children safeguarding training, 20% for level three children safeguarding training and 58% for adult level three safeguarding training.

Cleanliness, infection control and hygiene

Cancer services

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 clean and had suitable furnishings which were clean and well-maintained. There was a local cleaning policy for all areas. The policy included information for cleaning operatives working in restricted areas such as pharmacy, radiotherapy/diagnostics department. We saw that cleaning schedules had been completed in non-clinical areas including patient toilets.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The trust had recently invested in an ultraviolet (UV) cleaning regime to ensure all areas were thoroughly cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff told us they had enough personal protective equipment (PPE) to feel safe and were able to follow Public Health England (PHE) guidelines. We saw staff wearing PPE and was appropriate for their role throughout the inspection.

There was an up to date infection control policy which referred to other relevant policies such as hand hygiene. There was a COVID-19 policy to support additional cleaning and staff risk assessments. Ample personal protective equipment was available in all the departments, and we saw staff used it.

There were sinks for hand washing for staff in clinical areas and sinks and hand gel for patient handwashing; before entering the wards, there were posters on display to remind all visitors including staff to wash their hands.

We received samples of the latest hand hygiene audits for the oncology and haematology wards; audits for May 2021, Wards 621 and 622 (for April) exceeded the trust target of 90%, ward 624 was 89%, 623 59% and there was no result for ward 625.

We reviewed samples from the March 2021 infection prevention and control performances audits around hospital acquired infection, for both haematology and oncology ward. On wards 622, 624 and 625 over 90% of patients were screened for MRSA for ward 623 77% were screened.

It was also noted that wards 622, 624 and 625 had some period of increased incidences around hospital acquired Clostridioides difficile (C.difficile is the familiar term). C.difficile is a germ (bacterium) that causes severe diarrhoea and colitis. We spoke to the senior team around infection rate, they said many of the cases were from patients on regular antibiotic regime or recently had effect from their cancer treatment and they were reviewing all hospital acquired infections closely. Following on from their recent assurance visit on wards 622, 624 and 625 in May 2021 a key recommendation was to acquire a universal end of bed hand gel dispenser to ensure good hand hygiene practices.

There were spill kits throughout the departments where chemotherapy was administered, staff were trained in the management of blood and cytotoxic spills. The fluid used in the spill kits was in date.

Staff were tested twice a week for COVID-19 using lateral flow tests and *Polymerase chain reaction* (PCR) once a week or when required. Staff who were at a greater risk from COVID-19 had a risk assessment and were supported by the hospital. All in-patients were COVID-19 tested on admission and then every 72 hours, day case treatment patients were tested up to 48 hours before treatment.

Environment and Equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well. However, resuscitation trolleys were not secure.

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff disposed of clinical waste safely. There were systems in place for disposal of all waste including cytotoxic, clinical and radioactive. There was a waste audit for the different types of waste.

The design, maintenance and use of facilities, premises and equipment followed national guidance. The cancer services were at an early stage of working towards the Macmillan Quality Environment Mark (MQEM). The MQEM is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.

The breast unit was based at a nearby hospital across from the main site of Queen Elizabeth Hospital. The breast unit was a fully integrated diagnostic breast specialist service that provided all examinations and tests necessary to diagnose both benign and malignant breast disease. We found the breast unit department was difficult to find for patients that required to be seen at the breast unit from Queen Elizabeth Hospital. Queen Elizabeth Hospital was responsible for all facilities based at the breast unit.

There were fire exit signs and fire extinguishers throughout the department. All fire exits, and doors were kept clear and free from obstructions. The service tested fire alarms and emergency alarms on a weekly basis.

There were facilities for the administration of radiation to patients and for the disposal of any radioactive substance including toilet facilities for patients who had received a radioactive dose for their treatment. Radiotherapy equipment was subject to a strict maintenance and quality assurance programme including scheduled daily checks before any patient was treated.

Staff were trained to use equipment. Records showed staff had received up to date training on various pieces of equipment and so were considered competent to use them. Much of the training was undertaken by manufacturer's representatives or by the clinical educators. We saw records of equipment servicing with due dates for completion and completion dates recorded.

Radiotherapy staff had read the local radiation protection rules (local rules) and understood their roles and responsibilities. Local rules were in-date, displayed and all appropriate staff had signed to say they had read them. Staff told us and we saw evidence that staff had received relevant training on radiation risks.

All radiographer staff were required to sign in electronically before any treatment delivery. We saw signs to remind both radiographers on duty to sign in. We saw clear signage about who was in control of the area.

Intravenous fluids were not stored securely on the resuscitation trolleys. All seven resuscitation trolleys we inspected had open drawers. The cardiac arrest box and anaphylaxis boxes were secured with a tamper evident seal with expiry dates attached. However, the open drawers on each of the trolleys we inspected all contained intravenous fluids (500ml Glucose 10% (one bag) and 500ml Sodium Chloride (one bag).

The trolleys were checked daily and a full check was undertaken weekly. All checks were documented.

Fridge temperatures were checked and recorded, and we saw they were within the correct range. All checks were documented and were carried out every day.

Staff carried out daily safety checks of specialist equipment. We reviewed trust environmental audit data for all areas we visited and found all areas were compliant and above 95%. We also saw evidence that the trust carried out regular health and safety including fire safety checks and the trust were compliant with minor recommendations.

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

Within the radiotherapy department, as required by the Health and Safety Executive (HSE) who regulate the Ionising Radiations Regulations 2017 (IRR99), all areas where medical radiation was used were required to have written and displayed local rules which set out a framework of work instructions for staff. These local rules were displayed.

The radiotherapy department had the support of an external radiation protection advisor (RPA) and an onsite radiation protection supervisor (RPS). There was also support from a lead physicist who helped develop protocols and check the quality assurance processes on all the equipment.

Quality assurance systems were in place for the delivery of radiotherapy and were checked daily. The radiographers were supported by medical physicists and dosimetrists.

There was swipe access for staff into the radiotherapy department. Doors had controlled locking so to prevent accidental exposure to radiation. These were tested daily. There was a closed-circuit television and intercom in the rooms where radiotherapy was being delivered so that staff could speak with patients during treatment.

Staff had access to risk assessments online specifically for the service they provided. For example, the breakdown of the Linac machine.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff of all grades throughout the inspection demonstrated a good understanding of how, when and who to escalate if a patient was to deteriorate. Staff used the standardised early warning score (SEWS) to determine if a patient was scoring and/or required medical attention. All SEWS were recorded in patient electronic records.

At the pre-chemotherapy assessment, which was carried out two to three days before patients started treatment, patients were provided with contact details for the triage nurse and a red card outlining any symptoms they might experience that would suggest sepsis.

Staff were competent when faced with any specific risk issues. Clinical staff within oncology and haematology services completed an Acute Illness Management (AIM) Course.

Staff completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Clinical nursing staff within the oncology and haematology department had completed their training and competency around administering patient group directions (PGD's) antibiotics for patients admitted with query sepsis and to start intravenous antibiotics with no delay. PGDs is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

We reviewed the trust in date and version-controlled guidelines for "*The management of febrile neutropenia and infection in oncology and haematology patients".* It provided staff with clear instructions of how to manage febrile neutropenia and infection in immunosuppressed patients, what first line of antibiotics should be given and what antibiotic was suitable for those patients with an allergy such as penicillin.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

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. All staff in each of the departments we visited throughout our inspection attended a daily huddle led by the ward manager or senior nurse on duty. The huddle included an overview of the departments to discuss and identify a variety of quality and safety issues, bed capacity and staffing.

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified risks using a recognised tool and reviewed this regularly. Staff dealt with any specific risk issues and quickly acted upon patients at risk of deterioration.

Posters were displayed in the radiotherapy department to ask patients to inform staff if they thought they might be or were pregnant.

Staff completed a six-point check of name, date of birth, address, body part, clinical information and previous imaging checks. In addition, the service carried out daily identification checks, checks of the area being treated and this was completed daily before every treatment. This was in line with the legal requirements of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) to safeguard patients against experiencing the wrong investigations.

The haematology and oncology services carry out a rolling programme of audits to monitor compliance with venous thromboembolism (VTE) assessment and thromboprophylaxis. VTE is a condition in which a blood clot (a thrombus) forms in a vein. The trust shared their latest audits around VTE and peripherally inserted central catheter (PICC) lines at Queen Elizabeth Hospital Birmingham.

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.

Cancer services

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. Some consultants also had remote access to the electronic system and home working arrangements for reporting.

The trust used an electronic care records system and only authorised staff could access these with a secure password through the centre's online system. There were some paper records, and these were stored securely.

There were processes in place for sharing of information and different teams at the hospital could access patient information if they had appropriate access so that all the patients' information was stored together. This included referral information, the outcome of multi-disciplinary team meetings and an ongoing treatment record. The system produced discharge summaries for GP's.

The trust used an electronic system to capture decisions around do not attempt cardiopulmonary resuscitation (DNACPR) and the treatment, escalation and limitation (TEAL). This electronic system had several useful functions including mandatory fields and set reminders to ensure that all decisions relating to patient care were documented. This was used in place of ReSPECT, although senior staff told us the trust were presently adjusting the electronic system with the aim of it being an electronic version of the national paper ReSPECT form.

The clinical governance and patient safety team (CGPS) worked in partnership with the quality and clinical assurance team (QCAT) to facilitate a nursing documentation audit. Haematology and oncology wards were asked to undertake the audit during November and December 2020.

The overall results with performance was above 83%. The main findings for requirement to improve were based on the paper records documentation audit, around the basic documentation standards such as printing name and designation on every entry and ensuring the patient's name and registration number printed on every side of sheet. The inpatient internal transfer document (SBART) and the property disclaimers were not being routinely used.

We reviewed 14 patient records across all areas of oncology and haematology, and all 14 records we found similar themes around basic documentation not fully being completed such as patients name not recorded, hospital number not documented, missed date of entry on some assessments. Senior staff told us they were hoping to carry out another audit within their own clinical areas and offer further training or support for staff.

Staffing

The service did not always have enough nursing or support staff on duty. Staff had 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 and adjusted staffing levels and skill mix and gave bank staff a full induction.

The service did not always have enough nursing or support staff on shift. Staff we spoke with on ward 622 and 623 said they were often short staffed and at times shifts were run with rota gaps unfilled. Staff told us senior teams on the wards did try to find staff to fill in the rota shortages, many senior staff took on the clinical role if the ward fell short. Nursing staff told us they were mainly short staff on night duty.

Two junior nursing staff we spoke with were able to give us examples of some night shifts where they were left in charge due to staff shortages. One nurse said she was left on her own with one health care support worker to look after 12 patients, some patients were triggering on their observation chart, other patients were due their intravenous antibiotic,

another patient would be finishing their chemotherapy, staff felt unsupportive and unsafe at times. Staff told us they raised their concerns through the trust incident form and raised it with senior teams. We raised our concerns with senior nurses who told us this may have been a very rare occasion due to the pandemic and staff sickness as they had access to 'Pool' of around 20 nurses who were able to cover staff shortages on the ward.

According to the data we received from the trust for March 2021 there were 95.22 whole time equivalent registered nurses' vacancies within the division (five), 76% average fill rate of registered nurses on day shift and 82% on average fill rate on night shift.

However, we did not receive the latest figures for June 2021, according to many senior staff we spoke with throughout our inspection, many staff had left the service in March 2021 due to the merging of wards from another hospital site to Queen Elizabeth Hospital. Staff told us the vacancy rate at present was at 30% across the oncology and haematology departments, the trust were actively recruiting, and we were informed by September 2021 the trust would be at around 5%.

During quarter four the trust opened up additional inpatient capacity over and above recurrently funded establishments to support the surge demand associated with pandemic admissions. This required internal redeployment of staff to support additional capacity from across all departments whilst outpatient activity and non-essential support functions were reduced to focus on patient care, safety and quality.

Senior staff within the division we spoke with told us they had daily reviews of staffing requirements and escalation processes were in place to mitigate the impact of when planned staffing levels were not achieved. The use of temporary staffing was regularly monitored and reported monthly as part of a suite of metrics, with the continued aim to reduce the use of external agency staff. During the height of the second wave of the pandemic, the trust assumed a site based operating model, nursing and midwifery staffing decisions were made by site based divisional directors of nursing utilising their local knowledge and intelligence. The haematology and oncology wards did not use external agency.

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. The ward manager could adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants did not always match the planned numbers; this was evidently a challenge for many of senior managers we spoke with during our inspection.

The oncology and haematology services had a sickness rate of 6.1%.

Medical staffing

The service did not always have enough medical staff to support the cancer oncology and haematology services. Staff had 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 and adjusted staffing levels and skill mix and gave locum staff a full induction.

The resident medical officers (RMO) were available throughout the cancer services and would contact the patients' consultants or registrar if they had concerns about any patient and their treatment. Staff said the RMO was a great resource to support their work and for patient safety on the wards.

Cancer services

Junior doctors we spoke with from various departments within cancer services told us they felt supportive especially from the consultants and ward staff. Some feedback from the junior doctors was that "working in the services was very rewarding but also very busy, especially during the nights and weekends, at times can feel unsafe".

Some staff we spoke with said "the rostering system around unfilled shifts and sickness causes some issues". One example given was around difficulty in booking annual leave, even when requested six to eight weeks ahead of scheduling the rota.

Staff went on to tell us they were unable to obtain hot food after 8pm, there were little or no rest facilities for medical staff and the ward doctor's office on ward 621 was often commandeered for patient assessments.

Many doctors from various departments within the cancer services told us their training opportunities were restricted to clinics and less on the wards.

Some consultants fed back to us about their workload, which had increased significantly especially within the haematology service, since the merge of haematology inpatients from ward 19 at Birmingham Heartlands Hospital to ward 624 and ward 625 at Queen Elizabeth Hospital. We were told the impact of this had increased many of the haematologist consultant's workload and many consultants left employment during the merge.

The medical staff cover did not always match the planned number. The trust senior team told us they were finding it difficult to appoint a breast radiologist, which was challenging for the trust around seeing patients urgently within the two weeks wait for breast patients.

Many staff we spoke with us told us the staffing issues was because of "poor planning around the merger", "which exacerbated turnover of staff, resulting in many co-ordinators and trackers leaving the service". This alongside senior cancer management team changes. The trust currently had one lead cancer clinician post vacant and was actively trying to recruit to the Head of Cancer Services post. The merger was explored with the executive team who acknowledged the merger had occurred at the height of the COVID-19 pandemic without following due processes and they were working to ensure any additional changes included consultation.

We requested some data from the trust around medical staffing, turnover of staffing, sickness rate specific to cancer services. We received only trust-wide figures fill rate which was at 89%, a vacancy rate of 11%. This did not provide us with the relevant information in which we asked.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Medicine

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service used systems and processes to safely prescribe, administer, record and store medicines.

There was a formulary of systemic anti-cancer treatments (SACT) used by the trust with regimens which were tumour specific. These were reviewed every two years or more often if necessary. There was a process for off protocol treatments and off licence requests.

Cancer services

The chemotherapy units delivered vascular, injectable and oral SACT. There was a pharmacy team who screened prescriptions and checked and issued SACT products which were prescribed on an electronic prescribing platform and then supplied from an external supplier. There was pharmacy support on each area we visited. Staff we spoke with were very complimentary of the support they received from their pharmacy colleagues.

All medicines and SACT products were stored in appropriate, temperature-controlled environments which were monitored and recorded.

On site pharmacists were responsible for medicine reconciliation and ensured medicines were prescribed correctly based on laboratory results and previous cycles, including dosing calculations. Pharmacists also provided advice to medical teams if there were any discrepancies or interactions.

There was an extravasation management policy which was in date. The cancer lead nurse or clinical educational support for chemotherapy or the lead radiographer were responsible for the education of their staff in the prevention, identification and management of extravasation. Competencies were assessed every year.

We reviewed audit results for systemic anti-cancer therapy (SACT) process, safe and secure handling of medicine and drug compliance and if actions were taken where required

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All 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.

In the reporting period of quarter four 2020/21, the trust reported a number of incidents relating to the oncology service based at Queen Elizabeth Hospital, which included 10 serious incidents in the period January to March 2021.

The service had four never events between 2019 and 2020 relating to cancer services. Staff reported serious incidents clearly and in line with trust policy. Managers shared learning about never events with their staff and across the trust. There was evidence that clinical practices changes had been made as a result of feedback from the most recent never event.

Managers debriefed and supported staff after any serious incident.

Staff raised concerns and reported incidents and near misses. The trust had an in-date, version-controlled incident, accident and near miss policy which staff accessed electronically. All staff we spoke with knew how to report incidents using the service electronic reporting system. Staff received feedback from investigation of incidents. Any incidents that may have occurred during the week or had actions outstanding were also discussed during the daily morning huddle.

Cancer services

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. Staff were able to explain how duty of candour related to their role and clinical practice. The duty of candour is the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided.

The trust reported three serious incidents relating to delay in cancer treatment over a period of three months. We reviewed all three serious incident investigation reports, including the duty of candour response letters. We found the trust were open, honest and transparent in their responses and took full responsibilities for their actions. All incidents were fed back to the patient.

Is the service effective?

Good

We rated effective as good.

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. The trust used guidance and standards from a range of sources including the National Institute for Health and Care Excellence (NICE), the United Kingdom Oncology Nursing Society, the British Pharmacists Associates and the Society of Radiographers. This was referenced in policies and procedures. Staff had access to policies and standard operating procedures (SOP) which they accessed through an online system.

The trust used evidence-based technology in other radiotherapy treatments to reduce the side effects to other areas of the body which could be damaged during radiotherapy treatments. Patients could access intensity-modulated radiation therapy (IMRT) which helped reduce long-term side-effects of radiotherapy.

The trust carried out a regular review of their clinical guidelines register for oncology services. During March 2021, reminders were set to update their guidelines, those that had surpassed their review date were put on hold due to COVID-19 operational pressures. The oncology service currently had 17 clinical guidelines, four which were in date and 13 that had passed their date for review.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

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.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Dietetic support was available to head and neck cancer patients.

As part of the pre-assessment process before starting chemotherapy, patients completed a nutritional assessment as part of their patient record.

Patients could bring their own food into the hospital if they were going to be there all day. There was a patient kitchen on the young person unit and refreshments were provided by the hospital. There were drinks machines and cafés for patients across the hospital.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Pain was monitored as part of the holistic management of the patient. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients told us they received pain relief soon after requesting it with little delay.

Staff prescribed, administered and recorded pain relief accurately. Staff had access to pharmacy and medical support throughout the departments if a patient required additional input or advice.

Staff asked patients on arrival if they were feeling well or in any discomfort during their treatment.

Radiographers were competent in performing daily reviews and liaised with the oncologist or GP if patients required medical attention for symptom control.

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.

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes. Managers shared and made sure staff understood information from the audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. As per trust policy, each specialty was expected to have an annual audit programme, that run from September to September of each year.

The trust had an electronic auditing tool which highlighted non-compliances and created an action which was logged and tracked by appropriate staff. Audit outcomes could be seen by the team who had access to the system.

All staff contributed to the regular audits and took turns to complete them. Improvement was checked and monitored; the service had regular audit committee meetings to ensure there was oversight of improvements.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. The service lead told us they were not an outlier.

The trust regularly uploaded information relating to certain tumours such as lung cancer and colorectal cancer on those specific databases, to benchmark against other NHS providers to share patient outcomes and performances. The trust also contributed to the national cancer patient experience survey and the quality of life audit.

We received the trust 2019 national cancer patient experience survey (NCPES) results which were published in June 2020 along with the trust action plan for 2020/21.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

Some managers supported medical staff to develop through regular, constructive clinical supervision of their work. Some medical staff within haematology department said they were not always able to attend training specific to their role and felt unsupportive at times. Some staff within haematology told us since the merging of the inpatient ward at Birmingham Heartlands Hospital to Queen Elizabeth Hospital, training opportunities for medical staff had been affected due to increase of activities within the service and retaining staff.

Staff had their competences defined at induction, checked and updated at their annual appraisal meetings. Managers gave all new staff a full induction tailored to their role before they started work. Staff underwent an induction process to ensure they were confident and competent in performing within their role. We spoke with many staff of different specialities within the cancer services, staff were very complimentary of the support and the specific ward induction plans.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received clinical supervision and one to ones on a regular basis from their manager. Overall, data provided by the trust as of March 2021, demonstrated appraisal rates for all staff working within the cancer services based at Queen Elizabeth Hospital ranged from professional scientific and technic 25%, to administrator and clerical support at 100%.

The clinical educators supported the learning, development and provided regular training updates as needed. This supported staff when needed to revalidate.

Cancer services

All therapeutic radiographers, registered nurses and medical staff were registered as health care professionals and worked through an extensive competency framework which ensured they were competent to carry out each type of treatment.

Staff had to be signed off by the lead therapeutic radiographer for each treatment technique before they could work unsupervised. We saw the service leader kept record of all the therapeutic radiographer's revalidation dates.

All clinical staff working within chemotherapy services were required to complete their systematic anti-cancer therapy (SACT) training over a three-day introduction, followed by a competency workbook that required all staff to complete and pass before administrating any cytotoxic chemotherapy followed with annual update. The term SACT is used to describe all types of drugs used to treat cancer. Managers identified poor staff performance promptly and supported staff to improve.

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 (MDM) to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health and or depression.

All outcomes of MDM's were recorded in the patient record. As part of the referral process for systemic anti-cancer therapy treatment there needed to be an outcome from an MDM recorded in patient record.

Patients had their care pathway reviewed by relevant consultants based on individual cancer diagnosis.

MDMs during COVID-19 continued throughout the pandemic using online meetings or over the telephone; MDM attendances were regularly monitored as part of the referral criteria of peer reviewing documentation as part of the annual submission.

Seven-day services

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

Consultants or registrars led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services 24 hours a day, seven days a week.

Health Promotion

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

Cancer services

Patients' had access to a 'patient holistic' information room called the Patrick room. The Patrick room provided relevant information (provided by a private charity) for all patients with various health conditions.

The service had relevant information promoting healthy lifestyles and support for those patients going through radiotherapy treatment. We saw leaflets on display in the waiting area. Staff assessed each patient's health when admitted and provided support for any individual needs to live 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. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. 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.

The service accepted adult mentally competent patients who had been given sufficient information to give valid consent. In the event of a patient losing capacity during treatment or through treatment side effects for example a patient with brain metastases this was subject to a full multi-disciplinary team review.

If patients wanted to withdraw their consent during treatment this would have to be documented on the electronic patient record.

Staff clearly recorded consent in the patients' records. Staff understood the relevant consent and decision-making requirements of legislation and guidance. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was mandatory training for the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Some staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Overall, from data provided by the trust on 18 June 2021, the compliance rates for mental capacity act and deprivation of liberty to safeguard training were 90% which was within the trust target of 90%, although medical staff (consultants) was at 62%.

Is the service caring?

Good

We rated caring as good.

Compassionate care

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

Cancer services

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients were offered a chaperone if they required one and we saw a poster on display informing patients about the availability.

Patients were offered a holistic needs assessment to understand their needs outside their cancer treatment. This enabled the service to tailor care to the patients' needs as a whole and not just to treat their diagnosis. Staff told us that patients had personalised management of their treatment from the beginning to the end of their pathway. Staff followed policy to keep patient care and treatment confidential.

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. Patients said staff treated them well and with kindness.

Emotional support

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

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. Staff were aware of the lifechanging impact of a

cancer diagnosis and cared for patients in a supportive manner.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Patients individual needs and preferences were always reflected in how their care was delivered. Patients physical and psychological needs were regularly assessed and addressed, including nutrition, hydration, pain relief and anxiety.

Staff understood how demanding both emotionally and financially, daily treatment trips could be on patients and their relatives. The trust provided accommodation based on the hospital campus for those patients undergoing intense cancer treatment to allow them to have some home comforts away from home. Some patients told us how thoughtful and helpful this was.

Staff could describe how they supported patients who had exhausted treatment options and were moving onto a palliative pathway. They would have the conversations with the patients and their relatives and provide appropriate support. Some patients had been attending the hospital for a long time.

Staff told us they had been waiting for over five months for access to the psychological services support for teenage young adults. Staff were very concerned that this service was not available, they had recently completed a business case to ensure this service would be available.

We spoke with 18 patients throughout the inspection, all spoke highly of the trust, staff and support they received.

Understanding and involvement of patients and those close to them

Cancer services

Staff supported 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 talked with patients, families and carers in a way they could understand, using communication aids where necessary. The young persons unit had two carer coordinators across who were available to support across the whole pathway.

When a patient attended the hospital for their pre-assessment visit, the hospital would try to involve relatives in some of the discussions with patients so they were aware of the issues for patients who had taken systemic anti-cancer treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. The trust latest friends and family test (FFT) from inpatients was positive with a response rate of 97% against the trust target of 95%. Outpatients FFT positive responses had increased to 99% in March 2021 and met the trust target of 94%.

Is the service responsive?

Requires Improvement

We rated responsive 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.

Facilities and premises were appropriate for the services being delivered. The cancer services at Queen Elizabeth Hospital were spread over numerous different department sites at the hospital; Patient areas were comfortable and there social distancing was in place for staff and patients. Patients were quickly moved from the main waiting room to sub waiting areas so they could begin their treatment. Refreshments and water were available through the hospital for patients.

Patients' had access to a 'patient holistic' information room called the Patrick room. The Patrick room was not easy to find as it was not signposted at the main hospital site; many patients we spoke with at the main hospital site said the Patrick room was too far for them to visit as their treatment was at the main hospital or another building. Other patients did not know the Patrick room existed.

We found the Patrick room to be small in size with no privacy, when comparing to the broad amount of services that was provided at Queen Elizabeth Hospital. Many staff we spoke with told us there was very little provision for complementary services, distributed model for chemotherapy, haematology and solid cancers as well as acute oncology services. The Patrick room due to its location, had a limited cohort of patients, mainly those who came to the cancer treatment centre visited. Staff said it worked well for oncology as a specialty but not for the needs of the wider organisation.

Cancer services

Senior leaders within the cancer services told us they were looking into the Patrick room to have a more accessible approach for all patients, looking into having more access to patient information through virtual information, including health and well-being videos.

The breast unit department did not provide information leaflets for patients, the dedicated holistic room was based at the cancer treatment centre on the Queen Elizabeth Hospital site, which was not easily accessible. We saw one poster on display "you said we did"; main comments were around waiting times, the service amended clinic times, another comment was around "information could be clearer", trust promoted "my health" system; final comment we saw was "there could be more support", trust introduced holistic assessments and along with a monthly support group.

Lifts were available to access the first floor and could accommodate a wheelchair.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. When we visited the young person unit, we saw patients of older ages were placed in the same bay as a younger person. The young person unit (YPU) was provided for a person aged between 18 and 24. We asked staff about this and they told us since the COVID-19 pandemic, bed capacity had been an issue throughout the hospital and therefore at times beds within the YPU were used for medical outliers.

Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems, learning disabilities and dementia.

Managers monitored and took action to minimise missed appointments. Managers ensured patients who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

There were no specific audits for people with cognitive impairments in cancer services. Trust wide programmes for improving care of patients living with a learning disability or autism were overseen by the vulnerabilities steering group.

In April 2021, the vulnerability team conducted the first patient feedback survey of patients with a learning disability to assess the team's performance, identifying areas of good practice and areas where improvements could be made to improve the patient experience. This was the second month's results. The overall findings were positive. A total of 69 patients across the trust completed the survey, 31 were treated at Queen Elizabeth Hospital.

Staff understood and applied the policy on meeting the information and communication needs of patients living with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Cancer services

The trust worked with a charity and provided funding for complementary therapies during their chemotherapy or radiotherapy treatment. Some staff told us there was a therapy room at the hospital to provide acupuncture, reflexology and relaxation. Due to the pandemic some of these services had been moved on-line. However, we could not locate this room when we arrived on site and some staff were not able to direct us.

Staff recognised and considered the needs of patients' when they were accepted for treatment. A comprehensive needs assessment was completed for every patient before they started any treatment.

There was a wide range of patient information available to patients including information about wigs and the side effects of the cancer treatments based at the Patrick room. There was information available from the charity that was supported by the trust for patient health and well-being.

Access and flow

People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times. Despite not reaching the cancer national targets, the trust was using all available resources through the pandemic to ensure they clinically prioritised patients through their tracker to ensure patients were able to access the services.

Cancer waiting times are a key performance measure and many aspects of the cancer pathway are currently covered by a number of different national standards set out in the NHS. There are currently eight main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated as part of their cancer pathway; two weeks, one month (31 days) and two months (62 days) with the national target set at various percentages. NHS England also introduced a new 28-day diagnosis standard from April 2020 as part of their focus on improving early diagnostics and treatment.

University Hospitals Birmingham NHS Foundation Trust cancer performance against the national targets were as follows:

As of May 2021, trust latest breaches of patient waiting to be seen or treated:

- 14 days:
  - Breast Symptomatic – 25.5.% (93% target)
  - 2 weeks wait standard – 67.9% (93% target):
- 31 days:
  - 31 days first treatment - 79.7% (96% target)
  - 31 days subsequent radiotherapy – 90.6% (94% target)
  - 31 days subsequent chemotherapy - 93.3% (97% target)
  - 31 days subsequent surgery - 66.7% (94% target)
  - 31 days subsequent other- 100%

Cancer services

- 62 days:
  - 62 standards (including rare cancer) – 35.1% (85% target)
  - Screening – 59.1% (90% target)
  - Upgrade – 67.6% (90% target)
  - 62 days breast symptomatic – 33.3%

As of June 2021, the trust total 31 days waiting for anti-cancer treatment (this included those patients waiting for diagnostic biopsies) was 709 patients.

As of June 2021, the trust total 62 days patients waiting for diagnostics to progress their cancer pathway was 776 patients.

We reviewed the latest cancer improvement review meeting for June 2021. One of the highest concerns was around breast services backlog with an average of 260 referrals per week with a core capacity of 200. The team were looking at extra capacity and risk assessing the backlog and prioritising patients over the age of 50.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments, treatments or operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. Due to the COVID-19 pandemic, the trust was having to make critical decisions to ensure that patient safety was a priority. Priority meetings took place on regular basis to ensure all patients waiting to be treated were discussed and those who urgently needed to be treated were contacted and treated as soon as the hospital capacity would allow.

The service moved patients only when there was a clear medical reason or in their best interest. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Managers and staff worked to make sure they started discharge planning as early as possible. Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them.

Staff supported patients when they were referred or transferred between services. Queen Elizabeth Hospital was part of the University Hospitals Birmingham NHS Foundation Trust (UHB) and the cancer services were available across all sites, although Queen Elizabeth Hospital was the main cancer department for the trust. Some staff said at times it was difficult to share information with their colleagues at other sites as not all sites used the same IT system.

The cancer service was working towards reducing patient backlogs by providing a faecal immunochemical *test (*FIT) and intradermal (skin cancer) services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about the 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.

Managers investigated complaints and identified themes.

Cancer services

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Feedback from patients and carers were used to shape the services and provision of care and treatment. All patients were asked to complete a feedback questionnaire to address any issues as soon as possible. The service leaders reviewed all patient feedback. Any concerns were actioned promptly by the most senior staff members in the departments. An end of treatment satisfaction survey was also provided, feedback and scoring were then discussed at staff meetings, with a view to plan actions to improve.

Overall, from data provided by the trust on 18 June 2021, the trust complaints response performance for February 2021 was around 81%. This was a significant improvement from January 2021 where performance was between 64.8% and 68.1% for December 2020.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff had access to the trust corporate concerns and complaints policy which was in date and version controlled. We reviewed three complaints relating to different services within cancer care at Queen Elizabeth Hospital. We found the trust responses were appropriate and in line with their trust policy.

Staff told us they would try to resolve a complaint at local level before the need for escalation.

Complaints or concerns was a regular agenda at the monthly team meeting. Managers shared feedback from complaints and concerns with staff and learning was used to improve the service.

At the start of COVID-19 pandemic, the trust saw a marked reduction in its ability to meet its target for responding to complaints. All open complaints were written to, to explain the delays and information was posted onto the trust website. All complaints were received and acknowledged at that time, with urgent cases escalated for prompt action. To manage expectations and give complainants a more realistic timescale for their complaint investigation, a discussion was held at a patient experience group in January 2021 with agreement to put all new cases from 25 January 2021 onto the trusts 65 working day response time.

Is the service well-led?

Good

We rated well-led as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills and abilities to run the service. Each department had a local leader, each lead within the departments held a daily morning huddle which was a structured and documented meeting aimed at resource and capacity planning. This included problem-solving any immediate issue, learning from incidents and complaints and key

messages/alerts for that day. We saw each leader had oversight of their department. However, some staff told us the executive and divisional level leads were not always able to make prompt decisions and felt the service lacked oversight. Others felt they were not able to complete training and that the service lacked investment in clinical-academic excellence, disconnect between other services and the executive leadership. However, some staff fed back to us they felt the recent transplant programme merger was progressing well, there was some collateral damage but felt the teams were much stronger and aligned.

The leaders had the skills and abilities to run the service. We saw evidence they understood and managed the priorities and issues the service faced which included the importance of carrying out relevant audits in the middle of a global pandemic and having policies to support and underpin the service provided.

Staff felt supported by both their immediate line managers and the senior leadership team. Staff we spoke with were proud of the work that they carried out.

Leaders understood the challenges around quality and sustainability and were able to identify the actions needed to address them through gathering relevant information on which to base any decisions on where the service needed to improve.

Senior leaders worked effectively within the cancer alliance network.

We spoke with staff who had recently been seconded or promoted to senior level. Staff felt leaders encouraged them to develop and felt supported to apply for senior roles. Staff told us they received regular learning sessions for their personal development.

We spoke with some medical staff who said they felt supported but felt frustrated not being able to see their patient within national targets due to the pandemic and their 'wish list' was to be able see all patients waiting to be seen urgently as soon as possible. Many clinicians carried out clinics over weekends to ensure they saw as many patients as possible.

We spoke with eight medical staff working within the haematology services who told us they felt unsupported by their leadership team; many said since the merge of services from Birmingham Heartlands Hospital to Queen Elizabeth Hospital their workload had increased significantly and felt they were not able to review all their patients in a timely manner and that many of their colleagues had left the service due to the merge; which had left gaps within the speciality.

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. Leaders and staff understood and knew how to apply them and monitor progress.

When we spoke with staff, many said their biggest vision was to improve the cancer services, improve their national target and to be the best in what they do. We reviewed the trust 2020/21 strategy implementation plan, cancer services priority was to improve the 62 cancer GP referral and screening standards, and to be able to increase capacity for elective and emergency patient if the COVID-19 pandemic allowed.

Cancer services

Some staff commented on the information services, that the information based at the Patrick room was only available at the cancer treatment centre, and that plans were in place to improve patient access to information and that it was a very important part of patient pathway journey.

Cancer leads were positive about the development work around the succession planning for a clinical nurse specialist role and the education programme for opportunity and progression within career pathway and encouraged students and nurses to work within cancer services. There were plans in place to embed cancer nursing associates within cancer services and look at the skill mix within the teams.

Staff told us cancer services needed to work with other divisions for job plans and employment to widen and improve the quality of the service.

Culture

Most 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.

The majority of staff felt respected, supported and valued. Medical staff within haematology felt there was low morale amongst the staff and did not feel listened to or supported. Senior teams told us the merging of haematology services had caused disruption in the team, but the move was discussed with the team before the pandemic, and feel staff are now beginning to settle and are becoming a strong team. Senior leaders told us the restructure had been difficult, but things were settling.

Staff throughout the department were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with said they enjoyed working at the hospital and that they were not afraid to raise issues or concerns. They said they were listened to and action was taken if appropriate.

Staff we spoke with showed compassion and care for the roles they performed and the people they cared for. It was also clear there was a genuine commitment from staff to improve the service.

Some staff told us of a good team working culture, staff helped each other. Staff told us morale was positive.

There was an open culture where staff were encouraged to report concerns and incidents. Throughout our conversations with staff they displayed how the cancer service were focused on the needs of patients living with cancer.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. All incidents had a dedicated person responsible for investigation and completion of an action plan. Staff carried out daily safety huddles where a review of the previous day was carried out. Patient complaints, incidents and any lessons learned were regularly reviewed during staff monthly meetings.

We reviewed a sample of senior sister team meetings; we found many staff attended these meetings. Each department within division five had opportunities to feedback; main topics of discussion were around staffing, training, capacity, COVID-19 and staff wellbeing.

We reviewed six samples of haematology and oncology morbidity and mortality (M&M) review meetings over a three-month period. We saw details of lesson learned, examples of recommendations and discussions around appropriate decisions around DNACPR involving patients and relatives. Any learning from the cases were disseminated to junior staff and ward matrons. Staff told us the trust wide M&M system was in early development to ensure consistency in the recording of discussions.

There was a wide ranging meeting structure to support the governance structure which included the haematology and oncology morbidity and mortality meetings, trust chemotherapy working group, senior management team divisional board meetings, divisional cancer assurance meetings, radiation safety committee meetings and a radiotherapy service meeting. We reviewed a range of minutes from these which showed clear agendas, relevant discussions and actions

The trust had a radiation protection advisor, this is someone who is competent to advise employers on the safe and compliant use of Ionising Radiations. There were five radiation protection supervisors. The radiation protection supervisor oversees the work and make sure local rules are followed. There was a medical physics expert whose role was to oversee matters relating to radiation protection concerning medical exposure. The hospital was developing a dashboard for radiation safety audits.

The trust carried out a quarterly clinical governance and oncology patient safety report, the latest meeting was in May 2021. We found the report to be informative and robust with relevant data and information for true oversight of their oncology services.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a hospital risk register. The highest scoring risks for the trust were COVID-19, staffing issues, waiting times and performance and delays to treatment pathways and the backlog for breast referrals. Senior leaders told us each risk was allocated to the division to operate a solution.

The main themes of incidents within cancer services was around patients missed diagnosis and delays to treatment. The trust was continually working on improving their multidisciplinary meetings with regular peer review, improving systems to ensure they were appropriate and that pathways were in place to prevent any further delays for patients in the cancer journey.

Cancer services

The majority of clinical staff we spoke with told us the biggest challenge for cancer services was around length of time to treatment, many said, “this challenge was exacerbated by the COVID-19 pandemic,” “it was previously problematic, but was seeing improvement”, however, “more patients are presenting themselves to the service at a later stage of their cancer diagnosis”. The trust carried out regular review of harm and are beginning to see an increase around the potential risks from delays, no patient had come to harm.

The trust provided us with their cancer performance reporting dashboard. University Hospitals Birmingham cancer related performance and activity reports were available for all relevant staff through a Health Informatics (HI) dashboard. In addition to cancer performance/activity reports, the dashboard also contained cancer services specific output reports looking at numbers tracked and delays to cancer tracking. Both by individual co-ordinator and by tumour sites.

All data was shared and reviewed at the trust cancer improvement group (CIG) and the chief operating officer group (COOG) which was chaired by the trust chief operating officer and attended by the divisions’ managing directors. Once reviewed the information was disseminated down to the local management teams to share with their local teams.

Staff we spoke with in the radiotherapy department understood their responsibilities under IR(ME)R and they followed the trust’s procedures. Performance dashboards were used for staff to discuss, benchmark and monitor performance at monthly senior management team meetings.

Patient quality group meetings were held regularly, this meeting was to review any radiotherapy dose queries, to ensure the service followed The Royal College of Radiotherapy guidance for prescription or non-protocol doses.

The trust oncology services had one external visit in March 2021, findings from the visit were two minor non-conformances were identified, relating to dosimetry outputs (requirement identification and control) and physics computing (production and service provision). A follow up visit was due in September 2021. Following the March 2021 visit, the team developed an action plan to address recommendations and requirements.

We reviewed samples of meeting minutes from the haematology and oncology speciality oversight meeting (SPQM) for March and May 2021. Agendas had a set meeting template, areas of discussions were around issues or significant risks for escalation, operational performance, governance and safety, workforce, finance. We found the meetings to be informative and gave a short overview of the services and its performance.

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. Data or notifications were consistently submitted to external organisations as required.

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. Data or notifications were consistently submitted to external organisations as required.

Staff had access to information relating to risk management, information governance and how to raise concerns. Staff were knowledgeable about the trust’s incident reporting process.

Cancer services

There was a safety, quality and leadership forum that looked at performance across all cancer services across all the hospital sites. It looked at all audit data from each department and site and produced a quality dashboard that used the CQC key lines of enquiry. Any themes and trends could be identified.

The trust was able to look at data nationally and at hospital or site level. This enabled them to look at any themes and trends from the data. Managers could see if information from root cause analysis recommendations and action plans were embedded.

There were dashboards for the different modalities the service delivered, managers and staff were able to view and use the information to change and improve services.

Staff showed us how they accessed meetings and policies on the electronic system. Staff had access to up-to-date, correct and comprehensive information on patients' care and treatment in line with their roles and responsibilities. Meeting minutes were made available to staff if they were not able to attend meetings, this allowed all staff to keep up to date with changes.

Staff followed the trusts information governance policy; all staff were careful to lock computers when they were leaving the area to make sure patient data was kept private and secure.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients completed satisfaction surveys and results were analysed, and actions taken. All patients were asked to complete questionnaires and the information was collated onto a dashboard. Senior leaders shared this information with staff during monthly staff meetings.

Staff were encouraged to complete trust feedback surveys; this gave staff the opportunity to anonymously comment on how they felt about the service. The oncology and haematology wards had recently implemented the use of a staff suggestion box to give staff opportunities to share their thoughts anonymously. One example given was staff felt they had not enough food storage space in staff room, a new fridge was bought, another example was blood pressure monitor equipment the department bought more.

The cancer services lead had monthly meetings discussing patients' pathways with the local clinical commissioning group (CCG).

The trust carried out an ad hoc event with primary care services to promote an integrated care system. The trust met often with external agencies and West Midlands cancer alliance to work together to improve the delivery of cancer services across the trust. Cancer alliance at the trust also hosted a meeting every other month to discuss cancer performances against national standards.

The cancer services hosted three times a week operational meeting, engaging with colleagues across the system.

Learning, continuous improvement and innovation

Cancer services

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.

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.

The cancer services were working towards reducing patient backlogs by providing faecal immunochemical *test (*FIT) and intradermal (Skin cancer) services.

The trust was taking part in the trial testing called the "Grail test", which is a blood test that can diagnose over 50 types of cancer.

The trust was working on 10 quality improvement projects.

Staff were able to give examples of learning from incidents. One example given was around safer swallow, from a recent nil by mouth incident that identified multiple ways in which nil by mouth recommendations at the bedside were communicated.

The trust had implemented a learning from excellence project (LfE) as part of learning from excellence across the trusts. Learning from excellence aims was to provide a means of identifying and capturing learning from episodes of peer reported excellence or positive deviance. There were no LfE reports for Oncology to report during our inspection.

The haematology department had commenced an ambulatory autograft pathway to reduce the backlog that began in April 2021.

The trust had recently approved a purchase of a new ultraviolet cleaner for the oncology and haematology wards, this created assurances following on from recent COVID-19 outbreaks at the trust.

The cancer services had increased its ambulatory treatments to reduce hospital admissions; along with rolling out the COVID-19 vaccination services for local people.

The pharmacy team based on the oncology site had recently developed a patient information booklet regarding alcohol content in chemotherapy which won a prize at the British Oncology Pharmacy Association (BOPA).

The trust therapy team within the cancer services were piloting a study for patients requiring therapy through their allograft transplant, therapy support included physiotherapy, occupational therapy, nutrition and dietetics. The therapy teams offered pre-rehabilitation advice, education and included outcome measures taken pre-transplant, on admission, post-cells before discharge. The team currently had two pilot groups, one seen pre-treatment clinic and the second group seen on admission.

During COVID-19, the dietetic teams altered their practice to try and prevent admissions to the oncology wards reviewing patients virtually. They also supported the nurses with inserting nasal gastric tubing in patients undergoing radiotherapy and chemotherapy in an outpatient setting to prevent patients to have further weight loss and prevented hospital admissions.

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.

Urgent and emergency services

Inadequate 

Is the service safe?

Inadequate 

Our rating of safe went down. 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 and made sure everyone completed it.

All staff received and kept up to date with their mandatory training. The trust set a target of 90% for the completion of mandatory training.

The compliance for mandatory training courses as of May 2021 for registered nursing staff, medical staff and non-clinical staff in urgent and emergency care at Birmingham Heartlands Hospital was, 90% for registered nurses, 88% for medical staff and 95% for non-clinical staff. The training modules included manual handling, infection prevention and control and health and fire safety.

The mandatory training was comprehensive and met the needs of patients and staff. Emergency Department (ED) staff also had specific training, separate to the mandatory modules. Medical and nursing staff completed sepsis training to ensure they were competent to use the sepsis six screening tool and sepsis care bundles. Staff completed some dementia training in the trust's corporate induction. We saw staff could attend dementia study days to increase their dementia awareness.

Medical and nursing staff were provided with life support courses. Including advanced life support (ALS) for all consultants and senior nurses, immediate life support (ILS) for all registered nurses. All nurses in the children's ED were trained in paediatric life support, the consultants and the senior nurses had completed the European Paediatric Advanced Life Support course. Some of the medical staff we spoke with needed to complete a refresher course, however, due to the pandemic this had been delayed.

Managers monitored mandatory training and alerted staff when they needed to update their training. Some medical staff told us they were sometimes unable to attend training sessions, as they had to prioritise covering their shifts in ED. Staff and team leaders received an email alert when training was due. Team leaders planned ahead and booked staff onto training in advance where possible.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Most nursing staff received training specific for their role on how to recognise and report abuse. The completion of safeguarding level 3 for children for nurses was 79%. However, 70% of non-clinical staff had also completed level 3, which was a positive, usually non-clinical staff have safeguarding training for children up to level 2. Due to the children's ED being a separate department to the adults ED, the 79% compliance rate for nursing staff equated to all the paediatric nurses being compliant.

Medical staff received training specific for their role on how to recognise and report abuse. We saw 88% of the medical staff were compliant with safeguarding for children at level 3.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The trust's safeguarding team had been driving the PREVENT training to ensure as many staff as possible had received the training. PREVENT training included training to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. Nursing staff were 90% compliant. Medical staff were 88% compliant and non-clinical staff exceeded the 90% target at 95%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. This was in line with the trust's policy for safeguarding adults and children. Nursing, medical and administrative staff we spoke with could explain the process of safeguarding a patient and provide us with specific examples of when they would do this.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Policies for the protection of adults and children were in place. They supported staff to identify different types of abuse and provided guidance on the provider's policies and procedures. Guidance supported staff to report abuse to external organisations such as the local safeguarding authority who could take action to investigate concerns. The trust's safeguarding policy was easily accessible on the trust's intranet. Staff would also contact the trust's safeguarding team for additional safeguarding advice if required.

Reception staff completed safeguarding checks to determine if children were subject to a child protection plan or were known to be on a vulnerable child register. Nursing staff also explored social care arrangements with parents and children during the initial assessment stage. Staff noted any previous attendances to determine if children were frequent attenders, or where children presented with similar injuries which could suggest harm or abuse. The parental responsibility status of attending adults was considered at the point a child was registered at reception and was further explored during the initial assessment stage. Nursing staff recorded brief summaries of these discussions within the initial assessment record.

Child sexual exploitation (CSE) training formed part of the safeguarding training. Senior staff had attended a recent training day focusing on domestic violence, CSE and child trafficking. Staff were knowledgeable about the CSE risks and told us it was a known risk in the local area. Staff would refer victims of CSE to sexual assault referral centres and obtain support from the local police force to raise concerns.

In the ED paediatric area, the paediatric liaison health visitors identified child safeguarding cases and monitored frequent child attenders. The patient's school nurse and/or health visitor would be notified if a safeguarding referral was made.

Staff followed safe procedures for children visiting the department. At the time of the inspection there were no visitors allowed. However, all staff in the adults ED would be aware of the safety measures and signs to look for with potentially vulnerable children.

The trust had up-to-date guidance on female genital mutilation (FGM), which was in line with national recommendations. Safeguarding training included FGM to ensure staff remained up to date. The trust's safeguarding policy also included FGM advice.

Cleanliness, infection control and hygiene

The service generally 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.

All areas were clean and had suitable furnishings which were clean and well-maintained. We saw that both the adult and children's EDs were visibly clean, tidy and free from clutter during our inspection. In addition, the clean utilities and storage areas were clean and generally organised. We often saw ED staff working effectively with the domestic staff to complete cleaning tasks, despite how busy the department was. However, in the waiting areas, we did not see cleaning being undertaken of the chairs. This was because they were in constant use.

We reviewed the departments infection and prevention audits from December 2020 to May 2021. The audit looked at the environment, hand hygiene and if there were any hospital acquired infections for the month, such as, MRSA. Environmental audit results were only recorded for December 2020 and January 2021 (98% compliance for both months). There were no environmental results for the remaining months. We further noted hand hygiene results were only reported in May 2021 (100% compliance). There were no hand hygiene results between December 2020 and April 2021. Staff told us the lack of audit results was due to overwhelming patient demand during the height of the pandemic. There were no reported cases of MRSA or Clostridioides difficile (commonly known as C. difficile) associated with the emergency department during the audit periods details above. What was not recorded on the audit tool despite the department continuing to manage patients presenting with COVID-19 symptoms, were any potential cases of patient to patient or patient to health professional transmission of the virus whilst patients were in the emergency department. This would have been of greater importance considering the persistent breaches of social distancing rules due to high attendances and increased occupancy in the department.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. We saw evidence of cleaning records; these were completed by staff on the shift for each area. Nursing and housekeeping staff told us, due to the high increase in patients' activity within the department over the last two months, cleaning regularly and checking could not always be done to the highest of levels. There were always patients accommodating each area, even throughout the night.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were hand hygiene facilities in all the cubicles within the department and wall mounted hand sanitiser dispensers in all corridors and main entrance. We saw all staff used correct hand hygiene techniques after patient care or when moving around the department. We saw staff actively encourage patients, relatives and visiting staff to use the hand sanitisers. There were dedicated hand sanitiser stations by the ambulance doors, which encouraged visiting ambulance crews to immediately sanitise, on arrival to the department, also at the main entrance for all walk-in patients.

All staff we observed adhered to the 'arms bare below the elbow' policy, these included, short sleeves, no watches, jewellery or nail varnish. This was in accordance with the trust's policy.

Since the pandemic staff told us they had all the necessary PPE to treat patients safely. We saw all staff wore masks consistently whilst in the department. Staff were required to carry out their own personal COVID-19 testing, this was in accordance with the national guidance for health care staff.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean' stickers were placed on all equipment, such as, patient trolleys, monitoring equipment and drip stands, to show they had been cleaned and were ready for use. Staff told us each cubicle was cleaned after each patient. We saw this being carried out.

Environment and equipment

The design, maintenance and use of facilities and premises were not fit for purpose. Staff managed clinical waste well.

The adult's emergency department was not fit for purpose. The ED was spread out across the building and did not support patient flow through the ED. This meant staff from the different areas could not always communicate effectively. The emergency physician in charge (EPIC) and nurse in charge were responsible for over-seeing the entire department including the ambulance assessment area, three separate areas providing "Majors" care, the high dependency unit, separate minor injuries unit, the majors waiting room, a small clinical escalation area, clinic 9 (which was opened during periods of surge) and the children's ED. Local departmental clinical leaders reported the existing layout was not conducive to safety or quality of care.

Since the pandemic, the resuscitation room had been relocated to six cubicles. This was to enable aerosol generating procedures to be safely carried out. The rooms were small and of very basic configuration. There was no resuscitation equipment kept in the rooms which meant in the event of an emergency, staff were required to leave the room to collect it. Staff told us they had not had an incident or any concerns that impacted on patient safety. However, the small nature of the rooms meant it would not have been possible for multiple specialties to be present to provide full resuscitation management to a seriously ill patient. The resuscitation area was due to be moved back to its original room however no-one knew when this was likely to happen.

Waiting rooms were noted to be crowded therefore patients could not fully observe social distancing rules. Nursing and medical staff had very limited line of sight of the waiting room and therefore there was a potential a deteriorating patient was not immediately recognised.

X-ray, computed tomography (CT scan), magnetic resonance imaging (MRI) were within a reasonable distance to the emergency department. However, theatres were some distance away.

The layout of the paediatric ED was fit for purpose. The department had a dedicated high dependency and resuscitation room which was well equipped. We noted whilst there was a trolley present in the room, there was no resuscitaire. Resuscitaires are used to support the stabilisation and resuscitation of new-borns. This had been recognised by the local team following a recent incident. As a result, a resuscitaire had been ordered but had not yet arrived at the time of the inspection. Arrangements were in place for clinical staff to collect a resuscitaire from the neonatal unit which was in very close proximity to the children's ED.

We noted seats in the waiting room were positioned such that patients faces could not be seen by clinical staff in the adults and paediatric emergency departments. Therefore, there was a risk clinical staff may not immediately recognise a deteriorating patient.

There was a dedicated mental health room available in the emergency department, which the team used to assess psychiatric liaison team and ED staff could assess patients with mental health concerns. The room was complaint with the Royal College of Emergency Medicine (RCEM) guidelines.

Patients could reach call bells and staff responded quickly when called. We saw evidence of this during observations in the major's area.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was fully equipped, checked each day and adequately stocked in the event a patient should urgently require resuscitation. A random review of prepared procedural boxes included those used for emergency thoracotomies were well stocked. We noted a small number of items including dressings had expired (March 2021); these were highlighted to nursing staff who were working in the ambulance assessment area where the boxes were stored and who advised they would replace them

The service had suitable facilities to meet the needs of patients' families. We were shown the room where they could take relatives, friends or carers to speak confidentially and if they needed somewhere to take some time out. It was comfortable and appropriate for its use.

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

Staff disposed of clinical waste safely. There was clear segregation of clinical and domestic waste bins, with clear information in what is disposed of in each.

Assessing and responding to patient risk

Staff generally completed risk assessments for each patient. They did not remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration in the minors waiting area.

During the inspection the department was extremely busy. Since the pandemic, patient's that present at the main entrance had to give a brief description of why they were there before they could book in. This was completed by a 'minors navigator' nurse. Once they had registered, they took a seat in the waiting area and would wait to be called through by the triage nurse, emergency nurse practitioner, or GP, depending on their complaint. However, due to the increased demand through the ED, the navigator nurse told us patients had to queue outside the department before they could even register. Once they had booked in, if there were no available seats in the waiting room, they had to go back and wait outside. Staff told us sometimes there were 10 or more patients outside. This posed a high risk, due to these patients not having been triaged or assessed. We observed one patient who reported being in extreme pain following an injury to their leg. Two hours after having first registered with the receptionist, the patient had not been triaged or clinically assessed contrary to the Royal College of Emergency Medicine "Triage Position Statement". At approximately 12:30pm on the second day of the inspection, there were 26 patients assigned to the minor's treatment pathway. Fifteen patients were waiting to be seen with the longest wait being three hours. Six patients were observed to be outside the entrance who were awaiting care and treatment. There was no clinical presence of this area and there was an inherent risk a patient could deteriorate without being noticed by a health professional.

The minor's navigator nurse told us to be compliant with social distancing there could only be 21 patients in the waiting area at one time. We observed 36 patients in there at one point in the afternoon, with patients outside waiting to book in.

Urgent and emergency services

During the inspection we saw four patients that had waited over an hour to be triaged. These were potentially unwell patients, but due to no capacity in the major's areas, they had to sit in minors and wait to be seen. One of these patients had been waiting outside for 30 minutes before having a seat available inside. National guidance states all patients attending ED should be assessed within a timely manner, usually 15 minutes, and be booked in within five minutes of arrival. This was not happening across the department.

During the inspection the department had received a high level of ambulance attendances. Due to the lack of inpatient bed capacity the patient flow had decreased. This meant the ambulance staff could not offload the patients into the ED in a swift, safe manner.

Emergency department staff consistently raised concerns about over-crowding in the department leading to delays in patients being seen and treated. On the second day of the inspection at approximately 2pm, 20 ambulances were held outside the department. Ambulance crews were held because of a lack of space in the department to enable them to hand their patients over. This led to patients being kept on ambulances for periods of up to two hours or more. On 3 June 2021, the longest wait for a patient to be handed over was three hours 20 minutes. In addition to the ambulances held outside the department, there were 101 patients allocated to the major's pathway and 30 assigned to minors. A decision to admit had been made for seven patients, four of whom had been redirected to the waiting room to wait for their bed to become available. Staff working in the resuscitation area received more than ten pre-alert calls within one hour leading to staff having to work quickly to stabilise patients and to then step-down patients to enable bed spaces to be cleaned and made ready for impending pre-alerted patients. The divisional leadership team were clear patients held on ambulances were the responsibility of the hospital. However, there was significant confusion as to the clinical oversight of these patients. Some staff reported medical practitioners would routinely clinically assess all patients held on ambulances. Others reported the clinical condition of the patients was overseen by the paramedic crew. At no time during the inspection did we see medical staff assessing patients who were held on ambulances. The senior medical staff told us they simply did not have time to be allocated to the ambulance bay to assess patients, due to only two consultants on the shift, and one would be allocated to the resuscitation area. The ED staff recognised the patients waiting to be offloaded were their responsibility, however, because they were in the care of health care professionals deemed it safe for patients to remain on ambulances. We saw a potential life threatening concern was not picked up by the ambulance staff with a patient that had been in the ambulance for more than two hours, it was only found once the patient had been brought into the department and assessed by the ED doctor. This was the risk the ambulance and ED staff were having to deal with every day.

A band 7 nurse was allocated to oversee the ambulance queue however they too did not clinically assess patients. Instead, we observed paramedics liaising with the Hospital Ambulance Liaison Officer (HALO) who was based at the hospital if they were concerned about the clinical condition of their patient. If there was a concern, the HALO would escalate this to the band 7 ambulance nurse who in turn would report this to the department nurse-in-charge who would then try and create capacity in the department to have the most clinically unstable patient offloaded from the ambulance and transferred into the department. There was no standard operating procedure for this area at the time of inspection. However, the department did have an action card, with who to escalate to once the department was at capacity and there were ambulances outside waiting to offload.

We spoke with 15 ambulance staff, and all had been waiting over 30 minutes, two over two hours.

The department had some clear patient pathways in place. These pathways included paediatric, majors and resuscitation stress pathways. We reviewed the operational policy for the paediatric ED that was in date and showed a

clear pathway for paediatric care. There was no pathway or procedure for corridor care or ambulances waiting to be offloaded. The senior leadership team for ED told us these were being signed off at the time of inspection and were subsequently produced to CQC following the inspection with assurances the processes were to be implemented and monitored moving forwards.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used the national early warning score (NEWS2) and the paediatric early warning score (PEWS). Staff in majors and the resuscitation area completed these observations, including a pain score, in accordance with trust policy, and staff knew the clear escalation process for patients who scored high. However, staff would escalate patients they were worried about even if they did not have a high NEWS or PEWS score.

Staff could obtain additional sepsis support when required from the trust's sepsis lead. Staff could easily access the sepsis policy available on the trust's intranet. Staff had recorded sepsis screening details on the NEWS2 and paediatric early warning scores (PEWs) records we checked.

Patients that walked into the department, but did not have a minor injury or illness, had to wait in the waiting room to be seen, whereas, if the department had capacity in majors they would be taken through to a cubicle. We saw when majors' patients were being seen in the minor's department, they would not receive regular observations as they would if they were being seen and treated in the appropriate area.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were consistently completed for each of the care records we reviewed during the inspection. Sepsis six care bundles were commenced, and we found from the three sepsis bundles we reviewed, appropriate clinical interventions had been commenced within the evidence-based recommendation of 60 minutes. However, this was not done in the minor's area if major's patients had to be seen there.

There were clinical pathways in place for resuscitation, trauma, imaging and emergency surgery. These were accessible to clinical staff on the intranet.

Staff knew about and dealt with any specific risk issues. Staff were aware of risks such as pressure ulcers and VTEs (venous thromboembolism). They carried out risk assessments such as skin and nutrition assessments and medical staff completed VTE risk assessments. The completion of VTE assessments had improved since the last inspection in November 2018.

The service had 24-hour access to mental health liaison and specialist mental health support. However, staff told us once they had referred a patient it took longer than an hour for the liaison team to arrive and assess the patient. This was a problem nationally not just at this hospital.

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.

Urgent and emergency services

Staffing

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. 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. However, during our inspection we saw nursing staffing levels were adequate due to the use of bank and agency. Staff told us during most shifts, half the team were bank or agency.

Due to the increased workload on the ED there had been numerous nurses leave. Also, due to the lack of training opportunities within the department, staff would leave to progress their ED nursing career elsewhere.

The matron for the department would regularly review staffing. The service had a rolling recruitment plan, which was well supported by the trust board, as they understood the staffing risks. Staffing was on the departments risk register.

At the time of the inspection, there was a vacancy rate of 21%. The highest proportion of vacancies at within the band 5 nurse cohort.

The senior nursing leadership team acknowledged significant challenges with staffing, especially at band 5. This therefore made it challenging to complete a rota which was balanced with staff who had the right skills and experience. The high vacancy rate also created challenges with ensuring there was enough resilience across the workforce to staff escalation areas, including corridors, with substantive staff. Staff working across the children's ED also reported significant challenges with staffing the department with registered children's nurses 24 hours a day, seven days a week. There was a good working relationship between adult and children's nurses and there was a recognition for the need to upskill adult nurses so they could support the children's ED roster. The lead nurse for the children's ED always ensured a registered and experienced children's ED nurse was rostered both day and night. A competency programme was in place and was overseen by the senior children's nursing team. Advanced children's clinical practitioners also supported the emergency department with in-reach support provided by a consultant advanced clinical practitioner (ACP).

A review of the roster showed before the end of 2020, the band 5 whole time equivalent (WTE) in post was as low as 30 with some 50 vacancies across the band 5 nursing tier. We noted significant recruitment had taken place with approximately 20 WTE band 5 nurses had started in the department since February 2021.

Further to our on-site review of the staffing establishment, the trust provided comprehensive information to us following the inspection. They reported the overall nursing vacancy rate was, at the time of the inspection, 46.55 WTE nursing roles, with the majority at band 5. The trust reported in the previous three months, the local team had successfully recruited 10 experienced staff nurses who were due to start in the following month, further complemented by another seven nurses who were awaiting a confirmed start date. A rolling advert continued for band 5 nurses with ongoing interview panels diarised with senior nurses. The trust reported no vacancies at band 6, and were in fact over establishment, and an advert was shortly to be run for three band 7 vacant posts. To further complement the substantive workforce, the local team was also working to attract additional bank and agency staff with three having commenced recently.

Although there were two WTE clinical educator posts shown on the roster, there was serious concern this funding had been transferred to the ED at Queen Elizabeth Hospital Birmingham. The concern amongst nursing staff was the lack of presence of clinical educators in the department could lead to a lack of supervision and support for nurses new to the department or new to emergency care nursing. We raised this with the divisional leadership team who reported the posts were a central resource and clinical practitioners were rostered to work across the three emergency departments.

The department manager could not always adjust staffing levels daily according to the needs of patients. Although daily staffing levels were calculated based on expected attendances, current attendances had outstripped historical datasets. This had resulted in patients being cared for in corridors as a means of staff enabling patients to be offloaded from ambulances. There was significant resistance from staff for patients to be nursed in corridors. A lack of privacy and dignity was reported as one factor however a lack of nursing staff was given as the driving factor. It was reported matrons from across the three emergency departments for which the trust owned had met with senior organisational leaders to discuss their concerns with the offloading and management of patients on corridors. Infection control challenges, fire safety and staffing levels were all highlighted as areas of concern. It was reported the fire officer had supported the notion of not managing patients on corridors. This was also supported by correspondence from the fire safety adviser who stated “As the proposed plan to treat patients in corridors not only contravenes the fire regulations, it could also cause patients to be put at much greater risk in a fire situation. Therefore, I strongly advise this plan does not go ahead”. Despite this position statement, we were informed the position of the senior management team was patients would be accommodated along corridors in accordance with a standard operating procedure which had been created. It was felt by the triumvirate management team that in order to address significant ambulance handover delays, as well as attempting to improve interdepartmental flow, so long as patients met the listed criteria from the SoP, it was appropriate and safe for patients to be managed on corridors.

Between May 2020 and April 2021, the department reported a qualified nurse turnover rate of 11.68%. This was higher than the trust average and was higher when compared to the qualified nurse turnover rate at Good Hope Hospital (4.65%)

Between May 2020 and April 2021, the department reported an unqualified nurse turnover rate of 11.11%. This was higher than the trust average and was higher when compared to the unqualified nurse turnover rate at Good Hope Hospital (10.34%)

The number of nurses and healthcare assistants did not always match the planned numbers. During the inspection the staffing levels matched the planned numbers for the shifts. However, staff told us this was not always the case. We saw evidence of this looking at staffing rotas.

Managers limited their use of bank and agency staff and requested staff familiar with the service. We saw since December 2020, 63% of agency staff had worked one or more shifts within the department a week.

Medical staffing

The service did not have enough medical staff at consultant level 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 were 10 whole time equivalent consultants employed by the service. Consultants were present in the department between the hours of 8am and 10pm every day. However, the limited number of substantive consultants meant there was a significant reliance on locum doctors to cover the 4pm to 10pm shifts. During the inspection we spoke with six consultants who all unanimously reported it was

extremely difficult to safely cover the emergency department, particularly when it was busy. Attempts were made to ensure at least two consultants were present in the department. However, poor departmental design, high attendances and increasingly unwell patients meant consultants felt pushed beyond their professional capabilities to maintain a safe service.

It was the consensus of senior staff who worked in the department an additional 14 whole time equivalent consultants were required to ensure the department was staffed appropriately. However, there was a perception among staff that a request for additional staffing would be rejected based on a lack of funding. It was reported within the last 18 months, five substantive consultants had left the department, opting to work at neighbouring hospitals.

The department employed a total of nine middle grade doctors who were at specialist training level four or above.

Staff across professions and grades raised significant concerns about night-time middle grade medical staffing. The master medical rota suggested four middle-grade doctors were to be rostered at night. However, a review of rosters and interviews with staff revealed this level of medical staffing was rarely achieved. We noted occasions when only one ST4 doctor and one more junior middle grade doctor was rostered to cover the entire department. The existing layout and footprint of the department was always reported to further greatly impede the clinical leadership abilities of the senior medical practitioner at night who reported extreme challenges with having appropriate oversight of the department. A review of information provided to us following the inspection confirmed a high reliance on locum staff to support the medical rota.

Junior doctors expressed serious concern about teaching and supervision opportunities in the department. They reported that in response to the significant increase in public demand, teaching sessions were cancelled at short notice and therefore teaching programmes were managed in a "haphazard way". Concern was raised about the visibility of senior clinical staff because of both the business and poor layout of the department. Whilst anecdotal, 80% of medical staff we spoke with reported they would not want to bring a relative to the department as at the time of the inspection because of the high demand, staffing challenges and poor departmental flow. Following a serious incident in 2020 in which a patient required urgent surgery and a blood transfusion following a misdiagnosis during an attendance twenty-four hours earlier, one recommendation was for the ED to recommence its training programme. This action point was reported as being accepted within the serious incident report and was marked as completed in August 2020 which was contradictory to the feedback from junior medical staff.

We observed three medical handovers' during the inspection. These were structured and despite the conditions in which people were working, medical practitioners were working hard to keep patients safe in what was a very difficult environment. Teams were observed to work well together with good communication and health professionals supporting one another.

Senior medic staff turnover for the period of May 2020 to April 2021 was reported as 12.2%. However, it was not possible to assess this turnover rate against the two other emergency departments because senior medical staff were coded to Birmingham Heartlands Hospital on the electronic staff record (ESR) system as staff were likely to work across the different sites.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up to date, however they were not always stored securely. Records were easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

The department relied predominantly on paper care records. In the majority of care records reviewed, they were concise and contained detailed care and treatment plans. Nursing care was seen to be well documented and provided a comprehensive record of care. Vital signs for majors patients were recorded frequently and in accordance with the local NEWS2 criteria.

We asked the trust to provide us with audits they had completed in relation to patient records. The trust responded by advising us that processes were being adapted and changed in response to the recent pandemic. This included changes to governance processes and therefore formal record audits were not currently being conducted. Instead, the trust reported matrons and senior nurses carried out spot checks of patient care records to ensure they were accurate, complete and legible. We were however provided with audit results for physical observations completed between January and March 2021. Whilst the number of records audited were exceptionally low, in each record there was evidence of a treatment plan having been recorded. Where patients had triggered a NEWS2 score of four or more, there was evidence sepsis screening had been considered in each applicable case. However, there was generally poor compliance with regards to there being a peripheral venous catheter care plan being included in the audited records where this was applicable (50%, 33% and 80% respectively).

We noted that records for resuscitation patients were stored freely on trolleys located outside cubicle doors. This meant passers-by including other patients had easy access to records. The risk was marginally mitigated through the frequent presence of nursing and medical staff tending to resuscitation patients however there was no formal way for records to be stored securely. In other areas of the department, for example in the children's ED, records were stored on shelves attached to the wall within the nurses' station.

Medicines

The service had systems and processes in place to safely administer and record use. However, medicines were not stored safely in line with good practice or trust policies.

Staff followed systems and processes when safely prescribing, administering and recording medicines, however, there was no system in place for safely storing medicines. We identified poor storage of medicines with overcrowded and untidy cupboards including loose blisters, poor recording of fridge temperatures and lack of action when temperature out of range were identified. We also observed members of the clinical team struggling to find a medication on the department due the chaotic nature of the storage.

Staff told us there was no pharmacy service to the department apart from stock delivery. Staff reported stock management, including ordering and safe storage was the responsibility of all nurses, although we saw no one took ownership of these tasks.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Records we reviewed confirmed this. Staff told us patients received the information leaflet with their medicines if they took treatments from the department.

Incidents

The service managed patient safety incidents well. Staff recognised and reported 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 actions from patient safety alerts were implemented and monitored.

Urgent and emergency services

Staff working across the adult emergency care department knew what incidents to report and how to report them. Staff could provide examples of incidents they had reported and whether improvements had been made as a result. Staff reported in the event a patient experienced harm as a result of an incident, greater priority was given to changing practices when compared to incidents which were reported as a near miss.

The service had no never events reported during the preceding twelve-month period.

Staff reported serious incidents clearly and in line with trust policy.

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. However, there was a persistent theme from the emergency medicine directorate meeting minutes that compliance with internal timescales for applying the duty of candour was poor across the directorate. At the December 2020 meeting it was reported for October, of the three incidents which required the trust to discharge their regulatory duty of candour requirements, this had only been completed in one case. Improvement was noted with compliance at the March 2021 meeting with the directorate meeting the 10-day timeframe. However, it was again reported in the April 2021 minutes that compliance had deteriorated with part 1 compliance being reported as 40% and part 2 compliance reported as 0%.

Incidents were considered at both a local directorate level and again at divisional level. This ensured all relevant leaders were sighted on recurrent themes and trends across the division.

Safety Thermometer

There was no safety thermometer data available for the ED department as this national tool was designed to audit and monitor the quality of care in in-patient areas. Reporting to the national safety thermometer dataset had also been suspended in light of the COVID-19 pandemic.

Is the service effective?

Good

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

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 in a timely way.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Safeguarding policies were consistent with and referenced national best practice guidance for example.

Clinical pathways were based on best practice guidance and could be easily accessed by clinical staff. We observed good application of existing pathways including the management of patients presenting with stroke-like symptoms, gastro-intestinal bleeds and ST elevation myocardial infarctions (a form of heart attack).

There were however challenges with ensuring care was provided in a timely way as was required from some clinical pathways, for example initial clinical assessment. This was due to poor departmental flow and high attendance rates placing the department under extreme circumstances. High attendances of self-presenting patients meant at times we observed patients waiting for up to two hours and ten minutes from registering to being triaged. One patient who had sustained a head injury following a fall waited for one hour and 24 minutes before they received an initial clinical assessment. This was contrary to guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, we noted on occasions, due to delayed responses from specialist mental health act assessors, patients who required detention pursuant to the Mental Health Act for the timely delivery of care, patients were not always detained in a timely way. For example, one patient had presented to the department reporting a significant deterioration in their mental health. We observed the patient to be in obvious psychological distress. Although the patient had been seen by an emergency department physician within two hours of arrival and had been further assessed by a psychiatric liaison professional, the patient was still awaiting a mental health act assessment some twenty hours after they had first arrived in to the department. A review of the patients' record also demonstrated no formal capacity assessment had been undertaken for the patient.

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 fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Our observations supported the above statements.

Pain relief

Staff assessed and monitored patients to see if they were in pain. However, because of delays in patients receiving their initial clinical assessment, pain relief was not always given in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs. However, we observed patients who were waiting in the majors and minor's waiting areas to be in clear discomfort. One patient who presented with a limb injury was crying and was seen rocking backwards and forwards in their seat. Because of delays in the initial clinical assessment process the patient had not been offered any analgesia. A second patient who presented with abdominal pain was observed to be pallor in complexion and was pacing the waiting room. Again, because of the delays in initial assessment, the patient had not been offered any analgesia.

We observed once patients had been clinically assessed, they received pain relief soon after it was identified they needed it. We noted in a serious incident report, the pain management of a frail elderly patient who presented as a trauma call having sustained a number of fractures and internal injuries following a fall was only administered analgesia eight hours after first arriving in the department. There was recognition from departmental staff that pain management had been "inadequate for the injuries identified". Although the report highlighted the patient declined second line analgesia, there was no subsequent reassessment of the patients' pain score to determine the effectiveness of the administered first line analgesia.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved varied outcomes for patients.

The service participated in relevant national clinical audits. This included the Royal College of Emergency Medicine (RCEM) audits which were used to improve patient care.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards. The service participated in RCEM audits during 2019/20 which included care of children, mental health (self-harm) and assessing for cognitive impairment in older people.

In the care of children audit, the service met national standard one (Infants at high risk of potential safeguarding presentations are reviewed by a senior clinician whilst in the ED). For standard two 'A review of the notes is undertaken by a senior clinician when an infant, child or adolescent leaves or is removed from the department without being seen', the service carried out the review on one out of 24 eligible cases and therefore did not meet this RCEM fundamental standard. Standard three is an aspirational standard and recommends "Older child and adolescent psychological risk is assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents". During the audit period, the trust met this standard in 24% of eligible cases (30 records conformed out of 125 eligible cases). It is important to note that whilst the department did not meet standard three in every case, overall departmental performance was marginally better than the England mean.

In the mental health (self-harm) audit the service was slightly below the national average in two of the three standards. In the cognitive impairment in older people audit, the service did not attain fundamental standard one and was significantly below the national average. For developmental standard two the department did not conform to the standard in any of the four eligible cases. In aspirational standard three there were no eligible cases identified and so the department could not be ranked.

The unplanned reattendance rate (overall trust aggregated score) was marginally better than the England average (8.2% versus 8.8% nationally).

Competent staff

Although the service made sure staff were qualified and had the right skills, ongoing competency was harder to ascertain.

Nursing and Advanced Clinical Practitioners were mostly experienced, qualified and had the right skills and knowledge to meet the needs of patients. However, there was a lack of continuous professional development for nursing staff within the department, in part due to on-going operational demand and the associated COVID-19 pandemic.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us and managers were able to demonstrate all staff had a fully tailored induction for each role. Some staff reported a lack of support from clinical educators which in-part was associated with the department holding two vacant educator posts. There was some concern voiced amongst staff that the lack of clinical educators was likely to impact on the retention of junior nursing staff over time. There was a consensus amongst staff that operational pressures and significant workforce vacancies meant opportunities for training and development were stretched with some staff reporting very few opportunities being available.

Managers tried to support staff to develop through yearly, constructive appraisals of their work, however appraisals had been paused during the pandemic. The trust told us 64% of nursing staff and 65% non-clinical staff in the emergency department had received their appraisals as planned. 51% of medical staff and 41% non-trainee doctors had completed appraisals as planned.

Appraisals were suspended during the pandemic and all appraisal training was paused. The trust had since started to increase communications around appraisals and linking the appraisal conversation to wellbeing to support staff. The trust's medical appraisal process restarted in April 2021.

However, as has been reported in the safe domain, junior doctors consistently raised concerns with the inspection team about a lack of access to training and supervision. Operational pressures and poor visibility of senior clinicians (linked to high demands in the department) meant training sessions were cancelled at short notice. We noted from a review of serious incidents clinical supervision and junior doctor decision making processes were an area of concern and required on-going training. Misdiagnosis and a lack of senior clinical review were recurrent themes. Actions including the recommencement of training sessions were identified as serious incident action points, which, despite assurances from the local team these had been actioned, operational pressures meant this was not always the case.

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. This was observed during the inspection.

Staff worked across health care disciplines and with other agencies when required to care for patients. This was observed during the inspection.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression however as previously reported, there were often delays with patients receiving formal mental health act assessments.

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.

Health Promotion

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

The service had relevant information promoting healthy lifestyles as well as guidance on how best to recover from injuries and illnesses.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. In most cases, they followed national guidance to gain patients' consent. However, staff did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health in accordance with legislative requirements.

Urgent and emergency services

We observed most staff gaining consent from patients for their care and treatment in line with legislation and guidance. However, some junior medical staff did not always fully understand or appreciate the legal implications of applying elements of the Mental Health Act and associated code of practices, nor principles of the Mental Capacity Act 2005. Locum doctors we spoke with were not aware of how a lack of mental capacity to make a decision could impact patient care or the concept of informed consent.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

The trust provided training data which covered all three EDs across the trust. This showed 87% of nursing staff had received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

85% of medical staff had received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policies and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. However, following an event when a patient was restrained to enable staff to administer medication in order to help the patient's deteriorating mental health, we asked staff to provide us with a copy of the trust restraint policy. Despite best efforts, the local team could not readily locate the policy on the trust intranet or within local records.

Is the service caring?

Requires Improvement 

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

Compassionate care

In most cases, staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff tried to remain discreet and responsive when caring for patients. Staff worked hard to protect the privacy and dignity of patients, despite working in a heavily congested and busy department.

Staff did not always follow policy to keep patient care and treatment confidential. Staff maintained confidentiality as much as possible in the circumstances however, it was difficult to maintain patient confidentiality when patients were discussing issues in the queue of a busy waiting room or in a queue outside the hospital entrance. Staff were discussing potentially sensitive information which other people would be able to hear. Staff who worked behind reception also had difficulty hearing patients who they were speaking to through the intercom system, so patients often had to repeat information loudly.

In most cases, staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients living with mental health needs. However, we observed

a patient whose first language was not English, who was clearly distressed having been in the department for a considerable length of time awaiting a mental health assessment. The patient was observed to be standing in the corridor speaking loudly and showing signs of distress. Nursing staff made little to no effort to try and calm or reassure the patient.

Despite the demands of the department, we observed staff providing compassionate care to acutely unwell patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Although restrictions were in place which meant relatives were not always allowed to visit, we saw staff make appropriate exceptions where individuals were gravely unwell or who were increasingly anxious.

Emotional support

Staff did not always provide emotional support to patients, families and carers to minimise their distress. They did not always understand patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. However, during periods of extreme circumstances, there were occasions when we observed staff having “heated” conversations with patients and relatives in the waiting rooms. High environmental temperatures, congested waiting areas, long waits and a lack of information were all reported as reasons as to why both staff and patients became frustrated at times.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact a person’s care, treatment or condition had on their wellbeing and on those close to them. To help alleviate capacity issues in the department, restrictions were in place which meant relatives could not always be present with a loved one whilst they received care and treatment. Whilst we have reported above that exceptions were made in appropriate cases, we also observed examples of where staff were not as sympathetic or as understanding as they could have perhaps been. This was especially the case for patients who self-presented to the department. We observed nursing staff speaking abruptly with relatives who were seen to be challenging both trust and national visiting guidance. Security guards were available to support health professionals, however there were occasions when situations escalated beyond what we considered to be reasonable behaviour.

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 talked to patients in a way they could understand, using communication aids where necessary.

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

Staff supported patients to make advanced decisions about their care. Our observations supported the above statements.

Urgent and emergency services

Is the service responsive?

Inadequate 

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

Service delivery to meet the needs of local people

The service did not plan nor provide care in a way that met the needs of local people and the communities served. System working and the use of escalation protocols were poorly applied and understood.

Staff in the department raised significant concerns about access to, and the effectiveness of community based urgent care centres and auxiliary services used to support urgent and emergency care. Attendances to the ED at Birmingham Heartlands Hospital were reported to be increasing week on week, with demand outstripping capacity daily. Staff gave a range of reasons as to why attendances were increasing, including but not limited to a slow return of "business as usual" activity from general practitioners. This was observed to be the case during the inspection with patients reporting to reception staff they had opted to attend the ED because they were "unable to get an appointment with our general practitioner". One example included an adolescent who had been involved in a minor road traffic incident some three days before their attendance at the emergency department. The parent of the adolescent reported they had only been offered a teleconsultation with the GP which the parent thought was not appropriate, and therefore wanted their child "checked over" by a doctor. The receptionist attempted to redirect the parent and adolescent to a local minor injury unit, however this was refused. This was one of many examples we observed whereby the local population was accessing secondary care services when alternative options were available to them. This suggested a lack of population education in terms of the type of care emergency departments were designed to provide. Information was available at the entrance to the emergency departments which detailed the types of conditions that should be treated at an emergency department with contact details and addresses for alternative units for more minor conditions. There was little insight from the local divisional team as to the deliverables of the local accident and emergency delivery board. It was reported this was chaired by the trust chief executive but there was no formal representation or membership from front-line clinicians or the divisional team. It was therefore not clear what the local strategy was in terms of educating the public as to accessing urgent and emergency care provision.

Concerns were raised about the closure of a clinical commissioning group funded initiative which had been used to support the urgent and emergency care pathway. The "Badger" out of hours GP medical service had been reported by ED staff to have been a very useful initiative to help aid in decongesting the emergency department. However, staff reported this initiative had been discontinued with no notice being given to the local team. This meant the team had fewer alternative care pathways to refer low acuity/minor illness patients too. Instead, there was a requirement for the local team to manage those cases through the emergency department thus adding to increased congestion to the wider emergency care pathway.

In light of the recent pandemic, some changes had been made to clinical pathways which appeared to benefit patients. This included the consolidation of fractured neck of femur patients to one hospital within the group. This allowed for the consolidation of clinical expertise to be centred at one place. Not only was this intended to enhance recovery for patients through more timely access to theatres and rehabilitation services, but it also meant such patients would not be held for extended periods of time at Birmingham Heartlands Hospital whilst an appropriate bed was found on a trauma or orthopaedic ward.

Urgent and emergency services

During the inspection the emergency department was under extreme pressure. Attendances were reported to be at their highest level ever recorded by the trust. Patients were presenting with increased acuity and therefore required more intensive treatment initially to ensure they were clinically stable before being transferred to a ward. This meant there was reduced capacity across the emergency department to see new patients. On our second day of inspection, at approximately 2pm, 20 patients were being held on ambulances outside the department. We noted the department had received multiple pre-alert calls in very quick succession which placed the resuscitation area under extreme pressure. Staff worked efficiently to stabilise patients in order they could be stepped down to a less acute area within majors', allowing for the resuscitation cubicles to be cleaned and ready for the next patient. The resuscitation area was well managed by both a resuscitation practitioner and charge nurse however there was limited visibility from a consultant or the overall nurse in charge. We also noted very limited visibility from the divisional team before the 20 ambulances being held outside. Frontline staff reported they were operating on operational pressure escalation level (OPEL) three during the inspection and during the preceding days.

We observed the divisional executive manager to be present in the department at the time the 20 ambulances were held outside and there were extended waits to be seen times within the minors and major's pathways. It was not clear what escalation had occurred. Attempts were made for an informal divert of ambulances to a neighbouring trust however this request was refused on the basis the other trust was also holding a small number of patients on ambulances. There appeared to be no formalised system response, nor was it clear from the bed meeting we attended, what additional measures had been implemented to help decompress the emergency care pathway. The bed meeting did not consider what critical care capacity was available, nor whether any support was to be afforded by the wider health system. Emergency care staff felt they were "abandoned", and they felt the flow challenge was an issue to be resolved within division three, and specifically within the emergency medicine directorate. There was little support being afforded by speciality teams. We attended the acute medical unit at approximately 4pm and identified three acute medics and a host of empty chair and trolley spaces. The acute medics were not aware of the challenges the emergency department was experiencing which suggested communication and escalation processes within the hospital were being poorly applied. This was anecdotally reported to be a consistent theme. We also noted there had been very few pre-midday discharges from the hospital. The discharge lounge continued to operate with available capacity however this capacity was not being utilised.

Due to poor departmental flow patients experienced extended stays in the department. Staff reported they could not accept new patients who arrived by ambulance as has been reported in the safe domain. This resulted in patients having to wait on ambulances for up to two hours before their initial clinical assessment and their care and treatment could commence. We observed patients being cared for on trolleys or in chairs throughout the department. Patients who had been seen by a doctor or ACP and who were awaiting test results were redirected to over-crowded waiting rooms. Nursing staff reported fatigue and, in some cases, a general sense of pandemonium because patients were located across the large geography that was the emergency department. The environment itself did not lend itself to an area where individuals could rest and recuperate. High levels of pedestrian traffic, restricted bed spaces and extended stays in the department all meant patients reporting difficulties with sleeping and resting. Nursing staff reported challenges with helping patients with activities of daily living. However, records showed, and our observations confirmed nursing staff worked tirelessly to support patients as best they could.

During night shifts, when there were only one to two senior doctors working in the department and they were in resuscitation, staff in some of the major's areas would not know where they were. The staff had to use a tannoy speaker to find staff, including porters. We often found patients lost, due to the poor layout and signage of the department.

Urgent and emergency services

Patients found the layout of the ED confusing and were unable to locate the minor injuries or majors' areas. This was a particular problem for patients and visitors whose first language was not English as the signs were all in English only. Service leaders were aware of the constraints of the building and since the last inspection in November 2018, were planning to recruit volunteers to help signpost patients. We did not see any volunteers within the ED.

We found the waiting areas for minors and ambulatory majors patients had reduced seating for patients. This was to comply with the social distancing rules. This meant once the seats were used, other patients had to wait outside. We observed one elderly patient who was dependant on a walking stick, was asked to remain outside due to the waiting area being heavily congested. This was despite the patient raising concerns that they could not only walk very short distances, but they could only stand for short periods of time.

The hospital had a designated children's emergency department which accepted babies, children and young people. Although small, the waiting room had a small adolescent waiting area. Age appropriate toys were available for children and young people.

Meeting people's individual needs

The service was not fully inclusive and did not always take account of patients' individual needs and preferences. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. However, as has previously been reported in the effective domain, response times from some specialties was slow, resulting in patients experiencing extended stays in an environment which was not conducive to their recovery.

Signage of the department was poor and was only available in English and therefore did not meet the needs of the local population. Patients reported being sent to multiple areas within the department, with some patients confused as to why they were redirected to the waiting room after having been seen by a doctor.

The service did not have information leaflets readily available on display in languages spoken by the patients and local community. This was despite this being recognised as an area for improvement from previous inspections.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not access the service when they needed it and therefore did not always receive the right care promptly.

Managers monitored waiting times. Patients could not always access emergency services when needed and did not always receive treatment within agreed timeframes and national targets. According to data supplied by the trust, between 1 March and 31 May 2021 the service breached the one-hour ambulance waits outside of the department 379 times. This included 229 breaches in May 2021. Whilst on inspection, we saw at one time there were 20 ambulances waiting outside the department, with nine ambulances breaching the one hour wait time. The target time for patients to be admitted following arrival on an ambulance was 15 minutes. Staff were attempting to find beds within the hospital in order to move patients through the department.

Meetings held on the site were not always effective. There was a lack of forward planning and actions taken in dealing with bed and exit blocking. There were bed meetings held to discuss capacity in the hospital at 8am, 12pm and 3pm

which was attended by the site team and staff from departments across the hospital, including ED. In the bed meeting we observed the current situation was discussed, including both ambulance delays, majors bed capacity and potential discharges. There was a lack of future planning and a lack of actions proposed that would be put in place to remove some of the pressure on the ED.

Patients were often queuing outside the walk-in entrance of the department due to a lack of space and social distancing within the waiting room. The service had a navigation nurse and an ambulance nurse who were responsible for booking both walk-in patients and ambulance arrivals respectively. ED staff escalated patients who were awaiting beds in the hospital but could not be moved due to bed space.

Managers tried to work to make sure patients did not stay longer than they needed to, however this was not possible due to a lack of flow through the hospital and exit block of the beds throughout the wards. According to data supplied by the trust, between 1 March and 31 May 2021 the service achieved on average 70.6% performance against the four-hour target to treat, admit or transfer a patient from when they arrived at the department. The national target was 95%. Delays in clinical assessment and medical bed availability were listed as the most common reasons as to why patients were held in the department for longer than four hours. Despite there being over 13,500 admissions from the emergency department to an in-patient bed, the trust reported only one case where the patient remained in the department for more than 12 hours from the time a decision to admit the patient had been made for a non-clinical reason (i.e. no bed available). During the inspection we identified patients who had been in the department for more than 18 hours either awaiting a mental health assessment or who required an in-patient bed. It was reported that because patients may have already been in the department for more than four hours before a decision to admit order was made, it was unlikely the patient would breach the “twelve-hour rule”. Staff reported efforts were made to transfer those patients who were nearing the twelve-hour limit out of the department before “the clock expired” in order to avoid the trust declaring a twelve-hour breach.

Staff worked to make sure they started discharge planning as early as possible. Staff within the ED planned discharges for patients who were suitable as soon as it was possible. Staff could not always move patients into other wards within the hospital due to a lack of bed space.

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. This was supported by our discussions with patients.

The service clearly displayed information about how to raise a concern in patient areas. This was supported through our observations in the department.

Staff understood the policy on complaints and knew how to handle them. This was supported through our discussions with staff.

Managers investigated complaints and identified themes. The trust also identified themes from complaints. According to data received by the trust, between June 2020 and May 2021 there were 160 complaints received relating to ED.

Urgent and emergency services

Is the service well-led?

Requires Improvement 

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

Leadership

Senior leaders did not always have the skills and abilities to run the service. They understood but did not effectively manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

Local department leaders had the skills and ability to run the service, however the triumvirate senior leadership team were new in post and still familiarising themselves with the priorities. Local leaders had high standards of patient care and safety was a clear priority for them. Local leaders worked to act as advocates for patients and to promote patient safety. Most staff we spoke with said they considered local department leadership and management teams to be accessible, responsive and supportive. However, concerns were raised about the overall footprint of the department and lack of substantive staff meant leader visibility during times of surge or increased demand was extremely limited.

Junior staff reported not having access to or being able to locate the emergency physician in charge. Nurse-led shift leadership was non-apparent during the inspection. Whilst the matron was visible within the department it was unclear who was responsible for the oversight and co-ordination of the non-medical workforce from a shift perspective. The exception to this observation was during our unannounced evening inspection. We noted there to be a strong nursing presence. Strong efforts were made by the nurse in charge to ensure each patient had been clinically reviewed and reassessed and patients who had been in the department for extended periods of time had appropriate care plans. The nurse-in-charge was seen visiting each area of the department to check the welfare of staff and re-deployed their workforce to areas which needed it most critically. This level of oversight and leadership was absent during our day visits and contributed to our assessment and judgement that there lacked robust and appropriate situational awareness.

The service had a triumvirate senior leadership structure which included a clinical director, divisional head of nursing and a general manager who led the service. However, most staff said they rarely saw senior staff above matron level. Although they could describe the challenges at Good Hope Hospital as a result of having previously been based there, the triumvirate senior leadership team were relatively new in post and so were not fully appreciative or sighted on all the risks identified by the inspection team at the Heartlands site. We raised concerns about the extensive number of patients who were held on ambulances. Clinical oversight of these patients was extremely ambiguous. Whilst the trust reported they accepted the clinical responsibility of the patients, they reported there were arrangements in place with the NHS ambulance service for their staff to monitor and escalate patients to the relevant nurse as required. As part of the inspection we approached the NHS ambulance service who subsequently reported that no such formal process was in place.

Staff felt disconnected from the trust leadership and executive team and they felt the executive team did not understand what was happening on the site. Staff said they rarely saw members of the executive team.

Whilst trust and site leaders understood the challenges the service faced in terms of exit blocking and patient flow throughout the department, they did not manage the priorities in a way which reduced pressure and assisted staff treating patients within the department.

Urgent and emergency services

Vision and Strategy

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

The service had a strategy in place for the service, covering the ED departments across all hospital sites. The ED strategy was to deliver 'Right person; Right place; Right time'

The service had urgent and emergency care priorities that it was working towards with a system wide approach on which included consideration for; additional demand – effects of post lockdown, complex and minor cases, workforce challenges (annual leave/retention), paediatric viruses, COVID-19 variants and the flu.

Staff felt with the demand for emergency care steadily increasing year-on-year the situation of overcrowding, delays in ambulance handovers and risks associated with patient flow would only get worse unless there was a whole system approach to planning for and managing heightened demand.

Culture

Staff did not feel respected, supported and valued. Not all staff focused on the needs of patients receiving care. Staff felt the service did not have an open culture where people could raise concerns without fear.

Staff did not always feel respected, supported and valued by the site and senior leadership teams. Staff felt a lack of support from the site team and staff felt they were blamed and put under pressure to provide care in a way which they deemed to be unsafe. However, staff felt well supported by local leaders within the department.

Staff spoke of a bullying and a "done too" culture which we considered equated to a potentially toxic culture. Staff in the ED reported feeling disempowered to make the necessary changes. Examples included patients being offloaded from ambulances and cared for on corridors. Staff acknowledged the significant implications of not releasing ambulances in a timely way for the ambulance trust to continue to provide a safe service to patients in the community.

Governance

Leaders mostly operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. There were however some gaps and omissions in the supporting governance frameworks which could impact on the reliance of datasets used for providing assurance to the divisional management team.

The service had a clear governance structure. Staff were clear about their roles and accountabilities and where they fitted into the governance structure.

There were opportunities to meet, discuss and learn from the performance of the service. As part of the inspection process we requested minutes from divisional and ED governance meetings over the last six months. In the ED division clinical governance meeting there was a discussion of incidents, the risk register and any audits that had been undertaken. In the division three quality and safety meeting minutes, a report on emergency medicine highlighted the main areas of concern discussed. There was evidence that issues relating to ambulance handover times were also discussed in the governance section of the meeting. The risk register for the division, including EDs risks were also discussed. These meetings were well attended by staff across the service. We reviewed the minutes from the divisional

ED department meetings. In this meeting the individual ED got to discuss specific updates which were happening at their site. These were discussed along with specific risks and incidents. There was also an opportunity for nurses and junior doctors the give feedback, as well as specific sections for children's ED and areas such as minors. This meeting included an action log which was updated each month.

Audits were used to support the governance framework. However, there was limited compliance in terms of completion rates. For example, hand hygiene records were not consistently submitted to the central team, nor were environmental audits. Further to this the trust operated a NEWS2 observation audit. There was an expectation that 20 records from each relevant department would be reviewed and scored according to the audit documentation. For January, February and March 2021, four, three and eight records were audited respectively. This low level of audit activity provided little assurance as to the quality and compliance of local early warning protocols. A review of the governance and clinical safety minutes made no reference to the lack of records being audited. Whilst we acknowledge the COVID-19 pandemic placed extreme pressure on an already depleted substantive workforce, we observed Good Hope Hospital had reviewed 20 records in both the January and February audit returns. Nine records were reviewed by Good Hope Hospital in March 2021.

Compliance with the department discharging their regulatory responsibilities in regards of duty of candour was also an identified area of concern. Although there was discussion at multiple meetings about the importance of ensuring the duty was discharged in a timely way, as was required by the regulations, there seemed no long-term sustainable plan to resolve the issue.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They identified some risks but did not escalate relevant risks and issues and did not always identify actions to reduce their impact. Staff did not always contribute to decision-making.

The trust board received an integrated performance report on a bi-monthly basis. Clinical outcomes including the percentage of patients who had a recorded set of physical observations within 15 minutes of arrival was included. We noted that whilst Queen Elizabeth Hospital Birmingham consistently achieved the target, both Birmingham Heartlands Hospital (BHH) and Good Hope Hospital performed considerably worse which was consistent with our observations during the inspection. We noted overall performance for BHH was progressively deteriorating as compared to improving as would be expected if appropriate risk mitigations had been instigated. There was no evidence this metric was reviewed, scrutinised or mitigated against within local governance meetings to help support an improvement trajectory.

Issues such as access to training was an area of concern voiced to the inspection team by a range of health professionals including nurses, doctors and allied health professionals. As we have previously reported, serious incidents had identified access to training, especially for junior doctors were key recommendations. These recommendations had been made to reduce the risk of similar incidents happening again in the future. However, we found that despite serious incident recommendations being made, training was frequently cancelled, or postponed or junior doctors reported being too busy due to pressing clinical commitments to attend. There was no consideration to the importance of implementing the recommendations detailed in the serious incident reports and therefore the provider could not be assured they were taking all reasonable action to mitigate the risk and to prevent future similar incidents. This risk was further increased in light of the significant reliance on a temporary workforce, who may not be as competent as other clinicians attending recognised Health Education England accredited training programmes.

Information Management

This line of enquiry was not assessed as part of this inspection.

Urgent and emergency services

Engagement

This line of enquiry was not assessed as part of this inspection.

Learning, continuous improvement and innovation

This line of enquiry was not assessed as part of this inspection.

Good Hope Hospital

Rectory Road
Sutton Coldfield
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Description of this hospital

Good Hope Hospital serves North Birmingham, Sutton Coldfield and a large part of south east Staffordshire, including Burntwood, Lichfield and Tamworth. The catchment population is about 450,000. The hospital provides acute and general medicine and other specialist services including the Partnership Learning Centre, which is part-funded by the Medical School of the University of Birmingham. It has 430 beds.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory Training

The service provided mandatory training in key skills to all staff and usually made sure everyone completed it, but this had been impacted by the pressures of the COVID-19 pandemic across the trust in some areas.

All staff received and usually kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff.

With the impact of the COVID-19 pandemic since March 2020, staff at all levels said the trust had placed 'a hold' onto the requirement to keep training updated in an effort to meet the impacts of the pandemic response across the trust. Staff explained the trust's annual commitment to mandatory and statutory training had now restarted, but there would be a period of time for all staff to catch up.

Data provided by the trust on 14 June 2021 showed the overall compliance rates for staff in the medical care service at Good Hope Hospital was 90% which met the trust target of 90%.

Clinical staff usually completed training on recognising and responding to patients living with mental health needs, learning disabilities, autism and dementia. Most, but not all staff, had completed a dementia awareness training programme, but again, this had been placed 'on hold' due to the impact of the COVID-19 pandemic. Managers monitored mandatory training and alerted staff when they needed to update their training. Senior staff were making this a priority and had plans in place to address this over the next few months. In terms of oversight of compliance, a monthly report went to the trust's chief operating officer group (COOG) for inclusion in the workforce figure. The trust's education management group also met monthly; the same information was sent to this group and the trust's strategic education group quarterly.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, but this had been impacted by the pressures of the COVID-19 pandemic across the trust.

Staff received training specific for their role on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated an effective awareness of the trust's safeguarding processes and had received appropriate training for their grade. Staff knew how to follow safe procedures for any children visiting the wards. At the time of the inspection, visitors to ward areas were restricted in accordance with the trust's COVID-19 pandemic response plans.

Medical care (including older people's care)

Data provided by the trust on 14 June 2021 showed the overall compliance rates for staff in the medical care service at this hospital for level one children and adults safeguarding training were 97%, which was above the trust target of 90%.

The overall compliance rates for staff in the medical care service at this hospital for level two children safeguarding training were 93%.

The overall compliance rates for staff in the medical care service at this hospital for level three adults safeguarding training were 72%.

The trust had plans to train all clinical staff with a trajectory of 62% by quarter four of 2020/21.

The overall compliance rates for staff in the medical care service at this hospital for Prevent training was 74% which was below the trust target of 90%.

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. COVID-19 precautions were in place.

Infection prevention and control processes were robust. All ward areas were clean and had suitable furnishings which were clean and well-maintained. The service generally performed well for cleanliness according to feedback from patients and from local audits. Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw 'I am clean' stickers appropriately used on equipment throughout the service.

COVID-19 precautions were effective in all areas visited and we saw there was effective compliance by staff and visitors with the trust's infection, prevention and control (IPC) processes. Gel sanitiser and masks were freely available, and, at the hospital's entrances, staff ensured visitors complied with the precautions. Staff across the medical care service complied with social distancing precautions when required. Suitable posters were visible across the hospital, including wards, regarding IPC and COVID-19 precautions. Flooring in corridors and thoroughfares had appropriate guidance stickers to advise staff and visitors of appropriate social distancing measures. Staff were fully able to explain the COVID-19 precautions in their work areas, and actively encouraged all visitors to comply with them. Appropriate isolation facilities were available for patients with a suspected infectious disease.

Cleaning schedules were on display and toilets and bathrooms also had a nursing checklist for staff that had been completed in the areas we visited.

The overall compliance rates for staff in the medical care service at this hospital for infection, prevention and control training was 93%, which was above the trust target of 90%. Staff had received additional training to support the COVID-19 pandemic response.

Local IPC and environmental audits were carried out across all wards. For example, in May 2021, the AMU showed 88% compliance with MRSA screening and achieved 100% on the hand hygiene audit, 99% in the environmental audit. Ward 12 showed 46% compliance with MRSA screening and achieved 100% on the hand hygiene audit, and 98% in the environmental audit. Ward 14 showed 70% compliance with MRSA screening and achieved 100% on the hand hygiene audit. We saw clear actions were taken as a result of these audits to seek to improve compliance where required.

Medical care (including older people's care)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment followed national guidance. Service leaders spoke of the trust's estates' plan which planned the ongoing redecoration and refurbishment of wards in a regular cycle. We noted the wooden door frames and skirting boards in all areas of ward 11 were heavily 'chipped' and brought this to the attention of senior staff whilst on site. Due to the COVID-19 pandemic, this ward had not received the full planned redecoration, but senior staff acted immediately to have this addressed.

In order to create more capacity to help manage the bed capacity pressures of the COVID-19 pandemic, the day rooms on wards 11 and 12 had been converted to provide an additional two bed spaces. Some had piped oxygen and suction facilities, some did not (but oxygen cylinders and portable suction machines were available). The bed spaces had dignity curtains available. We noted some basic health and safety risks (including fire safety risks) in some areas. These were addressed at the time once we pointed them out.

In some areas (for example, AMU), there was a lack of suitable storage space for equipment and fire exits were blocked. This was brought to the attention of senior staff whilst on site and they acted immediately to have this addressed. We saw a fire risk assessment had been completed for AMU on 27 April 2021 and an action plan was in place to address the findings and recommendations. Each ward had a fire risk assessment and evacuation plan (which was clearly on display in all areas visited) that were reviewed regularly in line with the trust's policy. We also noted the quarterly fire safety report for the hospital dated 7 April 2021 in which assurance implications had been identified and remedial action plans developed.

Most wards visited were tidy and spacious, but we noted ward 11 was very cluttered, and most fire doors and cupboards were left open. We raised this with senior staff on the ward who took action to address it. When we visited ward 12 in the morning, we found the corridor was cluttered.

The AMU and MAU had now been redesigned with more beds and trolley bays and we observed a significant number of chairs for patients all with good spacing and a table. This included spreading into another area within the ground floor. When we discussed as to how the chairs were labelled/identified, we were told they did not have identifiers and any patient allocated a chair was visually located by their clothing. As staff were specifically allocated to care for patients in designated areas, and this included the chairs, it was felt this was acceptable. There was a potential risk that monitoring patient movement and safety (absconders for example) could be compromised.

During the pandemic, both health and safety audits and ward inspections were suspended throughout the trust and replaced with COVID-19 observations. This suspension had been lifted recently and audits were resuming at the time of the inspection. The trust provided information that showed seven ward environmental audits had been completed in the period 27 April 2021 to 23 May 2021. The trust provided a range of COVID-19 observational audits, which checked accessibility of PPE, staff compliance with IPC precautions, equipment, environment and social distancing measures. Clear actions were identified when required and recommendations identified. Photographs were included in these reports to highlight areas for improvement. Ward staff confirmed findings of these audits were discussed at daily ward safety huddles.

The overall compliance rates for staff in the medical care service at this hospital for fire safety training was 76%, which was below the trust target of 90%.

Staff carried out daily safety checks of specialist equipment, including resuscitation equipment. Some gaps in daily checks records were noted on wards and staff were informed. All equipment and clinical consumables were fit for use.

The service had suitable facilities to meet the needs of patients' families. Most wards had a visitors'/family room and the ones we looked at were appropriately decorated and provided a relaxing environment. The service had enough suitable equipment to help them to safely care for patients. In areas visited, we did not find any unsuitable equipment and all necessary maintenance checks had been carried out, including for hoists.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including 'sharps'. A 'sharps' bin is a container that can be filled with used medical needles and all categories of 'sharps' waste, before being disposed of safely. 'Sharps' bins seen were appropriately labelled and stored correctly. We saw regular ward audits were carried out and any shortfalls identified and addressed.

The hospital's resuscitation audit report for January to March 2021 showed that equipment compliance was 99%. It noted some issues around daily checks being recorded. Local leaders were aware of this and were monitoring ongoing compliance.

Assessing and responding to patient risk

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

During the inspection, we case tracked a number of patients' risk assessment processes and management. Overall, the care provided was safe and appropriate. In some cases, documentation could have been more detailed, and outcomes recorded in a timelier manner.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. The NEWS2 records we reviewed were almost all completed in accordance with trust policy.

Following an incident regarding nutrition, managers had been proactive in reviewing and taking actions following this event, and we found almost all staff were aware of processes for correct completion and review of the MUST assessment tool. The Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults, who are malnourished, or at risk of malnutrition.

There was variable completion of nursing risk assessments. We found examples in the records reviewed of where the trust policies for assessing and responding to risk had not always been followed:

- On Ward 15, one patient's urinary continence care plan had not been continued after initial assessment. One patient's Waterlow score was very high on admission with a score of 25 but the plan of care did not identify an airflow mattress and to have four hourly care. (Waterlow scores are carried out to assess skin integrity and risk of skin damage.) Another patient did not have a body map (for skin damage) completed and whilst the MUST assessment had been commenced, no weight was recorded. There was no fall bundle in place.
- On Ward 9, we noted one patient's care records noted a 'variable' eating pattern but the MUST record and care plan had not been completed.
- On Ward 12, the admission care plan for one patient was incomplete. The MUST/nutrition care plan was incomplete. There was no weight recorded: staff had measured the patients arm but had not taken the assessment any further.

We noted one patient with complex needs had been cared for in the AMU beyond the normal 24 to 36-hour period. Staff had explored the best options for this patient and there was no other ward able to meet their complex needs and as AMU had a higher staffing levels, it was safer to keep this patient on the unit.

Staff knew about and dealt with any specific risk issues. We found some improvements in venous thromboembolism (VTE) assessments in records checked. We noted one instance where a patient lacked a VTE assessment following transfer from another hospital. We raised this with staff at the time, who took action to address this. The trust's snapshot audit for VTE assessment compliance in May 2021 showed 27 out of 36 patients (75%) had an electronic VTE risk assessment performed. Of those, 21 (78%) had their VTE assessment recorded on the trust's clinical portal within 24 hours and one had an error identified in VTE assessment. Appropriate thromboprophylaxis was prescribed in 34 out of 36 patients (96%). Ward 12 were working with the national Emergency Care Improvement Support Team (ECIST) to improve ward rounds with a focus on VTE assessment and thromboprophylaxis.

We noted improvements in staff resuscitation training. Overall, the compliance rates for staff in the medical care service at this hospital for resuscitation awareness training was 97%, which was above the trust target of 90%.

The service had 24-hour access to mental health liaison and specialist mental health support. The matron for AMU and senior nurses voiced concern that there was an increasing number of patients living with mental health issues being held on the unit for a number of weeks because of a lack of mental health bed provision across the local system. They explained there were regular occasions when patients were detained under the Mental Health Act, having been placed on a Section, but had to have their care managed by registered nurses (rather than registered mental health nurses (RMN's)) as neither the nursing bank or the mental health team had staff to support them. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Whilst the matron felt staff were doing a 'great job'; caring for patients with risk of suicide was putting patients and staff 'under pressure'. They had ideas how to move this forward with the employment of either dual registered staff or having RMN staff available on the team for advice and support.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers generally included all necessary key information to keep patients safe. However, one morning handover record on ward 12 did not record any information for two patients. Staff assured us these patients had been discussed and appeared to understand those patients care needs.

Nurse staffing

The service did not always 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service generally had enough nursing and support staff to keep patients safe on the days we visited, but staff reported long standing staffing pressures across most wards, exacerbated by the pressures of the COVID-19 pandemic, especially pronounced in the healthcare of older people wards. The number of nurses and healthcare assistants did not always match the planned numbers, but local leaders reviewed the staffing on each ward throughout the day and flexed support as required. Recruitment, retention and support for staff was clearly of concern to the ward-based managers and this was having a detrimental impact on the delivery of personalised care.

Medical care (including older people's care)

Overall, there seemed to be sufficient staff within most areas visited. Where wards had less than optimal registered nurse (RN) staffing compliment, additional health care assistants (HCA) were usually deployed. Daily reviews of staffing requirements were undertaken by the divisions and escalation processes were in place to mitigate the impact of when planned staffing levels were not achieved. The use of temporary staffing was monitored and reported monthly as part of a suite of metrics, with the continued aim to reduce the use of external agency staff.

Some staff from across all areas we visited voiced concern that the workload was high. Some went on to say they were worried this was impacting negatively on the student nurses working on the ward, although student nurses we spoke with did not feel this way. Others felt more HCA's were needed because of the increasing number of patients with falls risks. Staff commented they were 'tired'.

We noted some delays in answering call bells and had to alert staff on three occasions when patients were calling for assistance. During another observation, we saw no staff in one bay overseeing a six-patient bay and alerted staff when one patient was trying to stand up. Staff responded immediately to support the patient. We were also aware of an incident in January 2021 where a patient who required one-to-one supervision, fell unsupervised and came to harm as a result. Although a staff member was allocated to provide one-to-one supervision, they were called to attend another patient urgently.

Senior staff told us of a number of initiatives they planned to implement within the care of older people wards. There was potential risk that unless these wards had sufficient permanent staff to meet the needs of the patients, to successfully plan and implement care plans and have capacity to spare staff to attend the planned ward development seminars, the initiative would not have the desired outcome. They said the trust's recent centralised recruitment drive had resulted in health care of older people wards not receiving the same allocation of staff as the acute medical wards.

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. The ward manager could adjust staffing levels daily according to the needs of patients. Data demonstrated actual staffing levels across the trust had improved between January and April 2021.

During January to March 2021, the trust opened additional inpatient capacity over and above funded establishments to support the surge demand associated with pandemic admissions. This required internal redeployment of staff to support additional capacity from across all departments whilst outpatient activity and non-essential support functions were reduced to focus on patient care, safety and quality. The service had reducing sickness rates.

The service had reducing turnover rates. Despite the COVID-19 pandemic, the turnover rates for nursing and ODP's had not increased: trust wide the turnover rate was 8% in the period January 2020 to January 2021 (a reduction from 8.6% in the preceding year).

The service had reducing vacancy rates. In the April 2021 'six monthly progress report – nursing, midwifery and allied health professionals staffing' report, it was reported the trust vacancy position for registered Nurses and ODP's continued to improve. Senior staff confirmed this. There has been a reduction in registered nurse and ODP vacancies of 82 whole time equivalent (WTE) between August 2020 and January 2021 (9.30% to 8.00% vacancy rate). There were 183 externally recruited registered nurses and five ODP's with conditional offers who were to start with the trust over the next six months. The trust had secured NHS England / Improvement (NHSE/I) funding for two programmes to support the recruitment of nurses who had gained their qualifications outside of the UK. The funding was being used to support different recruitment approaches

The trust had also seen an increase in the number of staff who had joined the staff bank over the last six months. This increase had been both internally through existing employees taking on additional hours and from external recruitment of new staff. The largest increase has been in registered nurses which were largely from existing staff joining the bank to undertake additional shifts. The majority of external recruitment into bank was by health care support workers. Recruitment continued on a monthly basis with rolling adverts for registered nurses and healthcare assistants.

The service had reducing rates of bank and agency nurses used on the wards. Managers made sure all bank and agency staff had a full induction and understood the service. Managers endeavoured to limit their use of bank and agency staff and requested staff familiar with the service. Overall, from data provided by the trust on 14 June 2021, the compliance rates for staff in the medical care service at this hospital for corporate and local induction training were above the trust target of 90%.

Medical staffing

The service 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

We noted the effective medical cover and rota arrangements in the service. Feedback from junior doctors was very positive, especially regarding the support they received. Junior doctors felt very well supported and spoke very highly of the consultants. The service had enough medical staff to keep patients safe. The medical staff matched the planned number in all areas visited. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends. Leaders said the service had reducing vacancy rates for medical staff and reducing turnover and sickness rates for medical staff. Trust-wide data provided on 16 June 2021 showed two specialities had high vacancy rates. This included acute medicine and short stay, as well as healthcare for older people.

Trust wide data provided on 16 June 2021 for medical staffing against the staffing establishment showed division 2 had 93% staff in post and division 3 had 74% staff in post.

The service had reducing rates of bank and locum staff. Medical staffing agency expenditure had reduced 63% from October 2020 to March 2021.

Medical vacancies were on risk registers and mitigating actions were in place, including revising the current adverts, exploring advanced practice roles and job planning was also as a priority.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. Overall, from data provided by the trust on 14 June 2021, the compliance rates for staff in the medical care service at this hospital for corporate induction training was comparable to the trust target of 90% and local induction training was above the trust target.

We observed a morning ward round on ward 12 with a consultant, one GP trainee, one registrar and two other doctors. Staff said the ward round was conducted in the same way every day with the poorly patients seen first and then each and every patient was seen starting from bed number one. Conversations were appropriate and focused on the needs of the patients.

Medical care (including older people's care)

Records

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

Patient notes were generally comprehensive, and all staff could access them easily. Whilst nursing notes had been completed every day and recorded the care delivered, there was little evidence of evaluation of care on some wards, notably the healthcare for older people wards. On the stroke ward, the daily nursing records were personalised and showed evaluations of care provided for example. When patients transferred to a new team, there were no delays in staff accessing their records staff said. Transfers forms were seen in records reviewed.

Records were mostly stored securely. The inspection team noted the variable oversight of some basic good practice and principles of care in some areas (for example whiteboards showing patient identifiable information, some computers left unlocked). Lockable trolleys were seen in use on all wards visited. We noted there was a wipe board (whiteboard) on the walls within a patient/public area with patient details on and on some boards, this included their treatment. We raised this with staff as compromised patient confidentiality. Senior staff took actions to address this at the time of the inspection. On ward 9, we found an unlocked storeroom with an electrocardiogram reading on a terminal. As this had patient identifiable information, we alerted the senior sister who removed it.

In December 2020, the trust conducted the first version of a new unified nursing documentation audit across all four hospital sites. As it was a trust wide audit, action points spanned all core services. Results showed generally positive findings, with performance for 17 out of 26 (65%) questions above 83% compliance. Performance was better in areas that used the trust's electronic record system.

The trust noted many of the areas of deficiency in paper records, such as missing signatures, dates, and times would be addressed through the full implementation of an electronic patient record system. Documentation audits for therapy services had been conducted for many years. The report for the December 2020 audit for the therapies medicine team showed effective compliance with the trust's standards with all 10 records audited showing over 87% compliance. A range of other therapies' documentation audits associated with medical care services were being used to contribute to a written review, with action plans as required, for the end of June 2021 quarterly report. We saw actions had been taken as a result of these audits to improve record keeping.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff mostly reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. Staff mostly stored and managed medicines and prescribing documents in line with the provider's policy.

We noted the variable oversight and ownership of medicines' management, particularly on ward 11. We found some poor stock management and some unsafe storage of medicines, for example loose blister packs. Controlled drug (CD) stock checks showed 50% were missed for May and June 2021. One patient had missed bumetanide as 'no stock' recorded but it was found on the ward. Our concerns were escalated on site and addressed the same day by pharmacy. On ward 10, we found the fridge locked but monitoring information was not available. CD stock checks showed 40% were missed for April and June 2021. On ward 9, CD stock checks showed 50% were missed in April and June 2021. Fridge temperatures were out of range 43 times in May and 11 times in June 2021. We raised this with senior staff who took action to address this.

We noted on ward 11 and 12, nurses delivering medications left the medication trolleys open and unattended whilst they took the electronic medication records to the patient bed side. We raised this with senior staff.

The trust carried out regular medicines' audits. The safe and secure handling of medicines (SaSHM) audit report (dated November 2020 for medical care services at Good Hope Hospital (target for compliance was 85%) showed four areas met the target and seven were below the target of 85%.

The report findings reflected, in the trust's view, the impact of the organisational movements that were necessary for the COVID-19 response. A joint approach from the nursing and pharmacy teams was recommended for the outstanding actions required following the audits, with actions being addressed at the time of audit where possible. Action plans were developed and shared with the area leads following the audits. A re-audit was completed in May 2021 and the results were in the process of being collated.

Ward controlled drug audits were conducted on a quarterly basis. In the trust wide controlled drug storage, ordering, receipt and record keeping audit report (dated March 2021), various themes of non-compliance were identified. The audit showed for medical care services at Good Hope Hospital (target for compliance was 85%) three areas met the target and eight were below the target. Recommendations and actions from the audit were put into place.

A business case was in development for the implementation of a pharmacy support service to support AMU aiding with completing an accurate medication history and reconciliation on behalf of the medical team. This was to include investigating any medication-related problems which may have contributed to the patients' admission.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We reviewed a sample of the specialty clinical governance and patient safety meeting minutes for April 2021 and saw clear references to National Patient Safety Alerts and Patient Safety Notices issued. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

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. The service had no never events on any wards. Managers shared learning with their staff about never events that happened elsewhere. Staff reported serious incidents clearly and in line with trust policy. Staff understood the duty of candour. From what staff said and records reviewed, they were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. The main issues and themes reported were similar across divisions. Pressure ulcers were the largest theme for most divisions.

Respiratory medicine had a much higher incidence of falls as their main theme than other specialities. In addition, staffing issues had consistently been reported in the last three quarters for the cardiology department. Incidents

regarding duty of candour (within the trust's 10-day target) showed poor adherence across the divisions. Actions and learning were shared with staff on ward handovers, ward safety notice boards, at staff huddles, in staff meetings, by email and safety bulletins and newsletters. Most staff found the safety boards were helpful in sharing key messages and learning.

We reviewed three recent serious incident (SI) reports pertaining to wards 23, 24 and cardiology. There was a clear record of the investigation of the incidents with a detailed analysis of the root causes, with adherence to principles of duty of candour being following, coupled with identification of lessons to be learned and actions plans in place to support cascade and embedding of the learning across the service.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The NHS Safety Thermometer provided a 'temperature check' on harm that could be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for all patients. Following consultation, the national collection of data stopped in April 2020 with the proposed developed of replacement data collection and reporting then impacted by the COVID-19 pandemic.

Staff used the safety data to further improve services. Leaders reviewed their team's performance with regard to the trust quality assurance dashboard and areas for improvement were cascaded throughout staff teams. Operational performance data was collated and reviewed at the trust's divisional board meetings. The divisional reports did not always provide a break down to specialty or ward, so it was always specific to the overall medical care service at Good Hope Hospital.

Is the service effective?

Good

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

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 up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies seen were reflective of national guidance. As per trust policy, each specialty had an annual audit programme, that ran from September to September each year. We reviewed a sample of the specialty clinical governance and patient safety meeting minutes for quarter four (January to Mach 2021) and saw each specialty had a clear audit programme and relevant action plans which included local audits, national audits, NICE (National Institute for Health and Care Excellence) guideline compliance, NCEPOD (National Confidential Enquiry into Patient Outcome and Death – 'Improving the quality of healthcare') compliance and clinical guideline compliance.

We noted reminders to update guidelines which had surpassed their review date had been put on hold due to COVID-19 operational pressures. We saw plans were in place to resume this work. A total of 122 out of 225 clinical guidelines were due for review.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers when required.

The trust provided examples of face to face ward visits by the end of life care team. For example, on 30 March 2021, there was a full review of all end of life and bereavement documents, equipment and policies. All wards were issued with up to date information laminated sheets, guidance on comfort observations and all equipment needed such as comfort packs and purple property bags. We noted there was a regular cycle of ward visits and audits with learning shared appropriately.

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. Patients confirmed this. Staff fully and accurately completed patients' fluid and nutrition charts where needed.Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. We saw referrals were and carried out as appropriate in records reviewed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools 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. Patients said they received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately based on records seen during the inspection. Documents reviewed during the inspection supported this.

Patient outcomes

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

The service participated in relevant national clinical audits.The trust participated in a number of national audits that included outcome data relevant to medicine care at Good Hope Hospital, including dementia, myocardial ischemia, heart failure, *chronic obstructive pulmonary disease* (*COPD*) and lung cancer. The trust informed us none of these were produced by hospital site or specialty; however, a summary was provided with the audits showing a variance and the associated responses.

Chronic Obstructive Pulmonary Disease Audit: (2019 report: October 2018 to March 2019) showed performance of one out of six measures as 'Within Expected Range' or 'Higher Quartile'. Five measures were in the lower quartile.

Medical care (including older people's care)

Heart Failure Audit 2019 Report: (2019 report: April 2017 to March 2018) showed performance of one out of five measures as 'Within Expected Range' or 'Higher Quartile'. Three measures were in the lower quartile.

Myocardial Ischaemia National Audit Project: (2019 Report: April 2017 to March 2018) showed performance of one out of two measures as 'Within Expected Range' or 'Higher Quartile'.

Audit of Dementia: (2021 report: April - September 2018) showed performance of no measures out of four as 'Within Expected Range' or 'Higher Quartile'.

Outcome data was reviewed at the trust's specialty and divisional quality and safety meetings through the quality and safety reports. These included Learning from Deaths. The reports seen included details of all national and local audits. Outcomes for patients were generally mixed. 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 and used information from the audits to improve care and treatment. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored. We saw action plans were in place to support improvements.

The endoscopy service was accredited by JAG. The aim of the JAG accreditation standards is to define a high-quality, safe and appropriate endoscopy service, delivered by a highly trained, highly supported and highly motivated workforce.

Competent staff

The service made sure staff were competent for their roles. Managers supported staff through appraisals however due to the COVID-19 pandemic, appraisals had been put on hold.

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. Staff on a number of wards all said they had received both corporate and local inductions, which had met their needs. An example of focused training support offered to staff was the trust's anticoagulation service continued to provide hot sessions focused on VTE prevention. Sessions had taken place in April 2021, directed at foundation year one (FY1), foundation year two (FY2) doctors and international trainees.

The trust's appraisal team sent out monthly appraisal reports which went to the distribution list for each Directorate; this included the director and deputy directors, operational managers and human resources manager. Monthly divisional workforce key performance indicator reports were discussed in the divisional partnership committee meeting which was held bi-monthly and in conjunction with trades union representatives and the trust board meetings held monthly. At these meetings the appraisal rates were discussed, and action plans put in place. Local managers could also check their teams' appraisals on the trust's learning management system, which showed who was in, due or out of date.

Managers supported staff to develop through yearly, constructive appraisals of their work. From information provided by the trust for medical care services at Good Hope Hospital, appraisal completion rates were low ranging from 38% for nursing staff to 75% for administrative and clerical staff. Plans were in place to address this.

Medical staff appraisal completion for the applicable Good Hope Hospital specialties was also low ranging from 14% for respiratory medical staff to 67% for diabetes medical staff. Plans were in place to address this.

Medical care (including older people's care)

Managers supported medical and nursing staff to develop through regular, constructive clinical supervision of their work. Junior doctors were very well supported and spoke highly of the clinical and educational support they received. The trust provided a range of examples of professional development and training offered to staff.

Clinical educators supported the learning and development needs of staff. Work was ongoing to refresh the support offer from clinical nurse educators as the wards returned to post pandemic ways of working. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Safety huddles took place daily on each ward to cascade messages and share learning. Managers usually identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff said this was usually the case pre-COVID-19 pandemic but a 'pause' had been necessary given the impact across the hospital over the past year. Managers identified poor staff performance promptly and supported staff to improve. We were provided with examples of when local leaders had taken action to drive improvements within staff teams.

A trainee nurse practitioner reported they were enjoying the work and felt they were very well supported by knowledgeable practitioners and their training programme was such that they had a well-planned rotation that allowed them to develop knowledge and skills across a range of specialties.

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. With the transition from the response that had focused on meeting the challenges the COVID-19 pandemic, staff reported relationships and support for each other across specialties was very positive. Meetings we observed were usually well attended and had the focus on a multidisciplinary approach to meeting patients' needs. Staff worked across health care disciplines and with other agencies when required to care for patients. Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Patients had their care pathway reviewed by relevant consultants. This was evidenced in our review of patient notes and from the ward rounds and handovers we observed.

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 weekends for acute medical service. Patients were reviewed by consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. A variety of information was available for patients and carers. Staff knew how to signpost patients to relevant external services when required. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Detailed nursing risk assessments were carried out.

Medical care (including older people's care)

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 measures that limit patients' liberty appropriately.

Staff mostly understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in almost all the patients' records we looked at. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

ReSPECT forms checked generally met trust standards. We saw improvements in use of ReSPECT forms, underpinned by clear Mental Capacity Act (MCA) assessments. ReSPECT is a national patient held document, completed following an Advance Care Planning conversation between a patient and a healthcare professional. We reviewed a sample of these forms in patient notes and found they were completed with notes relating to previous conversations with relatives and decisions to continue with ward-based care and treatment but not for resuscitation in most cases. Forms were signed by the consultants and legal guardians had been contacted. There was one case where information had been taken from a ReSPECT form from 10 months previous, without evidence of a review for this admission. Another case was a patient on ward 12 where the ReSPECT form had been signed but there was no evidence of contact with family or of an underpinning MCA assessment. We raised this with staff at the time of the inspection who took actions to address this.

Most staff received and kept up to date with training in the MCA and Deprivation of Liberty Safeguards (DoLS). The trust's safeguarding team provided MCA training through mandatory safeguarding training. The trust had recently commissioned a third-party to provide training videos covering the principles of the MCA, and how to conduct MCA and best interest assessments. This training reflected changes made to the trust's MCA policy and procedure last year. This training was to replace the current MCA mandatory training provided to staff.

Overall, from data provided by the trust on 14 June 2021, the compliance rates for nursing staff and allied health professionals in the medical care service for MCA and DoLS training were above the trust target of 90%. Whereas medical staff and additional clinical services were below the target.

Staff implemented DoLS in line with approved documentation. From our review of patient records, staff adhered to trust policy for both urgent and standard authorisation requests. Managers monitored the use of DoLS and made sure staff knew how to complete them. The trust conducted an audit each quarter, ensuring all areas were reviewed at least once per year. The trust's ReSPECT audit report (January to March 2021) included four Good Hope Hospital medicine core service wards. This report identified a few areas for improvement including ensuring forms were filed in the front of the patients' notes, documenting legal proxy status and specialty training doctor signed forms were endorsed by a consultant.

This hospital wide report (including medical care wards) showed out of 455 patients who had had died in this quarter, 423 (93%) had a do not attempt resuscitation order in place.

In terms of DoLS applications, the trust's safeguarding report for vulnerabilities steering group report (January to March 2021) showed staff at Good Hope Hospital had requested 44 applications in total in this period. Trust wide, the report reported there was evidence staff were completing capacity assessments to accompany the DoLS applications, there

was still work to be done to increase staff awareness ensuring they were completed for other decisions too. The trust's MCA and DoLS ward reviews (April 2021) report stated ward sisters were starting to proactively plan MCA and DoLS reviews by keeping separate charts and discuss during handovers. Wards reviewed in this period were wards 9, 11 and 14.

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. The trust had launched a number of posters regarding myths and misconceptions about MCA and DoLS and these had been emailed to all senior sisters, matrons and charge nurses across the sites. In quarter four of 2019/20, the trust undertook a safeguarding and MCA and DoLS assurance review across all inpatient areas and looked at training compliance and at what the wards had done to raise awareness. All wards were RAG (Red/Amber/Green) rated and those reviewed as non-compliant were to have a safeguarding review (which was started in quarter one 2020/21 and was nearly complete). The wards identified as non-compliant with the supporting information (wards 9, 11, 14 and 23) were visited by one of the adult safeguarding team and they were working with the senior sister or charge nurse to gather evidence and improve compliance.

Managers monitored how well the service followed the MCA and made changes to practice when necessary. The trust's newly updated consent procedure was due to be launched across the trust by 30 June 2021.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

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.

We observed some very positive, compassionate care by staff in most wards. Staff were mostly discreet and responsive when caring for patients. Staff generally took time to interact with patients and those close to them in a respectful and considerate way. From our observations, all staff were pleasant and polite to patients, other colleagues and to visitors. Staff attitude was generally positive, and the atmosphere was warm and welcoming; however; staff were working very hard to meet service demands on some wards, notably the healthcare for older people wards. Staff were able to give us a good summary of the patients currently on their wards/units. Most wards visited appeared calm, organised and the patients looked well cared for by staff, even though they were very busy. Interactions between staff and between staff and patients was warm and cordial. Staff were forthcoming, open and honest Staff were engaging with patients in a positive personalised way and the ward staff appeared relaxed and positive. All patients said staff treated them well and with kindness. Visitors were generally complimentary about the service provided by staff. Staff followed policy to keep patient care and treatment confidential as possible. 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. Staff demonstrated an understanding for and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were caring and kind, but some had clearly been impacted by the COVID-19 pandemic and the subsequent changes to their workload.

Medical care (including older people's care)

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 supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed this during our visits to the wards. Staff were empathetic and caring. Staff said they undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them. Staff gave examples from the COVID-19 pandemic of how sensitive information was relayed to patients and their relatives.

Understanding and involvement of patients and those close to them

Staff supported 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 talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff supported patients to make advanced decisions about their care. Staff supported patients to make informed decisions about their care. Patients spoken with gave positive feedback about the service. We saw examples of patient feedback on display in most wards areas and what actions staff had taken to make improvements.

The trust's carer coordinator service engaged with staff and carers to ensure carers were identified, recognised, and supported at the earliest opportunity. Staff were encouraged to attend carer awareness training and to refer carers to the carer coordination service, in addition to providing them with a carers pack. The carer coordinators regularly visited wards at Good Hope Hospital to engage with staff and establish whether there were any carers currently on site. Whilst this had been challenging during the pandemic, where possible this activity had continued. The coordinators also recently supported wards with repatriation of patient property by making contact with relatives and carers to facilitate safe return of property. This activity had enabled the identification of some carers who were not previously known to the service and enabled appropriate support to be given.

Is the service responsive?

Requires Improvement

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

Service planning and delivery to meet the needs of the 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, so they met the changing needs of the local population. However, these plans had been severely impacted by the COVID-19 pandemic. Staff knew about and understood the standards for mixed sex

accommodation and knew when to report a potential breach.Facilities and premises were not always appropriate for the services being delivered as some wards had their day rooms converted to provide additional bed spaces (for example ward 11 and 12) to respond to the acute pressures of the COVID-19 pandemic. Staff said ward capacity and number of bed spaces were to be reviewed.

Staff had access to emergency mental health support 24 hours a day seven days a week for patients living with mental health problems, learning disabilities and dementia. The trust wide vulnerabilities team were able to provide support either on site, or by telephone.

The service had systems to help care for patients in need of additional support or specialist intervention. Appropriate notification systems were in place to 'flag' patients who had specific or complex needs.

Managers monitored and took action to minimise missed appointments. Managers ensured patients who did not attend appointments were contacted. Staff said this had been impacted by the COVID-19 pandemic, but recovery processes were not in place to improve performance in this area.

There was an ongoing focus into improving the patient experience of discharge in the healthcare for older people service. There had been the introduction of a seven-day OPAL (older person's assessment and liaison) service at the hospital's front door since June 2020. This service operated Mondays to Fridays 8am to 8pm and Saturdays and Sundays from 8am to 4pm, working across the emergency department, MAU and AMU to reduce avoidable admissions of older adults and those with complex needs. The service was delivered by a multi-disciplinary team comprising of consultants, junior doctors, therapists, nurses and advanced nurse practitioners. They took a "home first" approach and worked closely with emergency and acute physicians within the hospital and with community services outside the hospital to ensure patients had the care and support they needed at home. OPAL was part of the Birmingham system-wide early intervention programme. Work was currently in progress to secure additional funding to allow this service to expand to provide seven-day cover 8am to 8pm.

A 'homeward audit' was also being introduced to understand the profile of the patients who were being transferred to the Homeward Centre, as well as the discharge outcomes of these patients. The Homeward Centre was originally set up as a therapy and nursing led ward to support patients who were experiencing delayed discharges.

We noted the potential improvements to be delivered from the reconfiguration of the acute medicine service and pathways. The service relieved pressure on other departments when they could treat patients in a day. In the acute medicine service, service re-design had included enhanced on-call rotas, redesign of the acute and ambulatory care pathways and enhanced medical cover on weekends. From a nursing perspective, the teams had peer reviewed each hospital site and had looked at the different services available. Staff at the Good Hope Hospital were looking to include dedicated discharge teams to help promote early discharges within the service. They were also looking into services for patients presenting with mental health issues, replicating the services offered at another trust hospital. Furthermore, the patient experience team was planning to review and enhance the patient journey for all of the acute medicine areas.

The stroke service had moved from ward 24 to ward 14 in response to meeting the challenges of appropriate bed space/ward configuration for responding to the COVID-19 pandemic. Whilst staff fully understood the rationale for this, the new ward environment was not as optimal as the previous one, they said.

Medical care (including older people's care)

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services wherever possible. They generally coordinated care with other services and providers.

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. Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Recognition of individual needs especially in relation to dementia, nutrition and hydration, disability and skin care was absent within some of the care records we reviewed, and the nursing summaries rarely gave an effective evaluation to help with discharge planning. This was notable particularly on the health care for older people wards. Leaders were aware of these issues and had plans in place to address them.

Staff told us the impact of the COVID-19 pandemic on the health care of older people service meant some wards (wards 11 and 12 in particular) were delivering a 'task-oriented care' approach and there were some gaps in a holistic person-centered care approach, particularly for those patients with cognitive impairment.

Use of the trust's dementia care plan/enhanced care bundle, and care passports were not embedded within the health care for older people wards. For example, on wards 14 and 15 staff stated they did not use any dementia care pathway documentation.

On ward 11, the matron recognised staff were only able to deliver care in a task orientated fashion and were not emotionally resilient enough to provide person centred care due to the ongoing impact of the COVID-19 pandemic. The ward was very busy. We noted one patient walking with no footwear and alerted staff, who responded immediately, and we also alerted staff to two patients calling out at times.

The trust's 'dementia: a positive approach to care' (PAC) educational program had recommenced, following suspension for 15 months due to COVID-19, in May 2021. Sixty-one members of staff had attended the first four sessions and included individuals across divisions and from diverse job roles. All healthcare for older people wards and the stroke ward at Good hope Hospital had an 'observations of care' visit since March 2021.

Reports for individual wards were produced and action plans were in place for each ward. We saw negative and positive communication examples were detailed in these reports.

From information provided, and from what matrons and senior managers told us, a range of initiatives were being implemented to improve the quality of patient focused care.

The trust's vulnerabilities team were on all hospital sites Monday to Friday to review and support staff with patients and if any concerns, they were escalated to matrons of the ward area, along with the matron and lead for vulnerabilities. The trust told us the vulnerabilities team continued to support medical care wards by providing support with complex patients and staff training.

The trust's vulnerabilities team were continuing to review patients in Good Hope Hospital medical care wards to implement the trust's learning disability/autism spectrum disability standards, supporting the clinical staff, and assisting in providing clinical care. The percentage compliance with the trust's learning disability/autism spectrum disability standards had increased due to the standards being implemented and reviewed daily by the vulnerabilities team. The trust's standard in relation to flexible visiting expected staff to be supportive of flexible visiting times to suit

the needs of the patient, carer and family. During the COVID-19 pandemic, the trust allowed relatives/carers of patients living with a learning disability or autism to visit or stay overnight. In April 2021, the vulnerabilities team conducted the first patient feedback survey of patients living with a learning disability to assess the team's performance, identify areas of good practice and areas where improvements could be made to improve the patient experience. We saw the overall findings were positive including positive feedback that reasonable adjustments had been made to improve patient comfort.

Wards were not always designed appropriately to meet the needs of patients living with dementia. The quality of the décor on some of the healthcare of older people wards did not always lend itself to a calming, relaxing atmosphere for patients living with a dementia. Day rooms had been converted to provide additional bed capacity on wards 11 and 12. This meant there was not always an appropriate environment for providing meaningful activities and stimulation to people with cognitive impairments. We raised this with senior staff who informed us of the necessity to provide additional beds because of the COVID-19 pandemic and plans were being drawn up to improve the healthcare of older people service.

Staff generally understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. However, staff awareness of the Accessible Information Standard (a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need) was poor in the areas we visited. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, and carers could get help from interpreters or signers when needed by accessing the trust wide service. We saw communication needs noted in records. We saw staff recorded patients' impairments, preferred communication medium and additional communication support needs. The trust had reviewed themes from complaints (from April 2020 to April 2021) from patients that were hearing or visually impaired and this review found communication accounted for 27% (23) of all the complaints, some problems included: patients denied access to Wi-Fi and no signing interpreter offered, failure to tell patients about delay in surgery, poor staff attitude, or deaf patient having difficulty understanding staff wearing mask. Actions were in place to address these themes. Staff had access to communication aids to help patients become partners in their care and treatment.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Appropriate menus to reflect cultural and dietary preferences were available.

Access and flow

People could generally access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients had been impacted by the COVID-19 pandemic.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers worked to keep the number of cancelled appointments, treatments and operations to a minimum. When patients had their appointments, treatments or operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Each division produced a monthly operational performance report. The June 2021 report showed:

- Division 3 trust wide: RTT dropped to 58.8% for older people in April 2021 (data shows steady drop since January when it was 77.9%).
- Division 3 trust wide: RTT dropped to 67.7% for stoke in April 2021 (data shows steady drop since February 2021 when it was 80.7%).

- Division 3 trust wide: RTT improved to 68.2% for therapies in April 2021 (data shows steady improvement since January when it was 62.34%).

Managers monitored patient moves between wards and services were kept to a minimum. Managers and staff worked to make sure they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those living with complex mental health and social care needs. Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them.

Bed manager roles had been replaced by flow co-ordinators. Flow co-ordinators had developed an increased focus on discharge process and reduction in empty bed time. A pilot had commenced in April 2021, with an increase in discharges shown during the weekend. We saw there was a focus on improving the patient experience of discharge to improve MDT engagement, improve leadership and accountability and improve patients and family involvement and communication processes.

Throughout the COVID-19 pandemic, there had been significant work with partner local authorities and community teams to ensure the smooth discharge of patients from the acute settings. The result of this work had led to a substantial drop in length of stay within the complex discharge hubs.

Managers and staff worked to make sure patients did not stay longer than they needed to. Data from the complex discharge hub (which covered all hospitals and was detailed in the trust's 'discharge and transfer of care data weekly report v1' (31 May 2021) and the length of stay data for Good Hope Hospital, showed there was an increase in the Birmingham local authority length of stay at Good Hope Hospital; this was partly due to twice as many patients with lengths of stay between 21 and 25 days. Discharge outcomes saw an overall rise in the percentage of pathway one discharges seen at Good Hope Hospital. (Pathway one is a different way of working for health and social care professionals that brings people out of hospital once they are no longer acutely unwell. Understanding and assessing the type of support people may benefit from, is completed in the comfort and safety of their own home.)

Staff supported patients when they were referred or transferred between services. We saw appropriate transfer documentation was in place. Managers monitored patient transfers and followed national standards wherever possible. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Outlying patients were routinely seen by their specialty teams, doctors told us. Managers worked to minimise the number of medical patients on non-medical wards, however staff told us this had been impacted by the COVID-19 pandemic.

Staff said board rounds were restarting after they had been paused as a direct response to the pressures during the COVID-19 pandemic. In response to increased length of stay, the deputy chief operating officer had set up a length of stay working group to monitor and improve timely discharges.

The service moved patients only when there was a clear medical reason or in their best interest. Staff endeavoured not to not move patients between wards at night. In terms of bed moves, the trust informed us there was regularly reported data however we were not provided with specific details for medical care wards. Staff reported bed moves for non-clinical reasons were not carried out wherever possible, but the COVID-19 pandemic had meant the focus was on maintaining an appropriate environment to reflect the COVID-19 positive status of patients.

Learning from complaints and concerns

It was usually 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.

Medical care (including older people's care)

Patients, relatives and carers knew how to complain or raise concerns. Patients and relatives said they knew how to give feedback or raise a concern if required. The service clearly displayed information about how to raise a concern in patient areas. Posters and information leaflets gave appropriate advice how to make a comment, give feedback or raise a concern. Staff understood the policy on complaints and knew how to handle them and were aware of how to report an issue to on the wards visited. Managers investigated complaints and identified themes. Ward leaders and matrons monitored all complaints and ensured learning from them was cascaded. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. Ward huddles were used to provide immediate feedback and share learning from any complaints. Staff could give examples of how they used patient feedback to improve daily practice and gave examples such as improving responsiveness to telephone calls to the ward and additional ward clerk cover was secured to help with phone cover on wards to help improve communication with relatives.

The patient experience group and care quality group were attended by all the divisional directors of nursing so they could comment on any other actions being taken to address themes and shared reports with key divisional colleagues. Key themes and learning points for Good Hope Hospital medical care wards (in quarter four 2020/21) were around communication (especially with families in the context of visiting restrictions), discharge arrangements and planning and clinical treatment delays. The deputy dead of patient experience was leading a quality improvement (QI) group around communication and how this could be improved.

Complaints' response performance for the divisions had been under pressure in the last quarter. At the end of January 2021, however, agreement was reached at the patient experience group that all new cases would be placed on a 65 working day timescale to ease the pressure on clinical and other divisional colleagues. Existing complainants were also being contacted to advise responses may not be as timely as the trust would like due to COVID-19 pressures.

Compliments were collated, logged and reported by the patient experience team. They were forwarded to anyone named individually, or to the service lead for the team/department mentioned. Senior multi-disciplinary colleagues were also copied in so good practice was recognised and celebrated at all levels. We saw examples of 'thank you' letters and cards in the wards we visited.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The senior management team were present, supportive and clearly knew their staff and their challenges. They were compassionate and kind to each other and to the ward staff. They appeared to be a cohesive team working hard for the benefit of all patients, staff and their local community. They had an ambitious vision for the future and stated they were very proud of their staff and the hard work they have put in during the COVID-19 pandemic. Recruitment, retention and support for staff was clearly of concern to the ward managers and leaders were aware this was having a detrimental

impact on the delivery of personalised care and staff morale. Leaders were continuing to deliver the staff experience improvement plan, which was working to address the key themes identified in both the annual and quarterly surveys and responding to patient and visitor feedback. Supporting staff recovery with the trust's staff wellbeing programmes remained a high priority. We saw very passionate, committed matrons, local managers throughout the service. Consultants were fully engaged and committed to deliver the best possible services for their patients.

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. Leaders and staff understood and knew how to apply them and monitor progress.

Staff were generally aware of the trust's strategic aims to always put the needs and care of patients first, and to become a community asset for Birmingham and beyond. Each division had a local strategy and vision to improve services. Most staff were aware of the trust's overall strategy and vision and how this was reflecting in their own local areas. Division 3 were about to commence the completion of 'strategy on a page' for 2020/21. Therapy services had a strategy planning day scheduled on the 23 June 2021. The stroke service was in the process of arranging a date for their strategy development.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care wherever possible. 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 at all grades, were always friendly and welcoming and we had open and honest conversations with a wide variety of staff across the service. We saw there was a community feel to the hospital.

Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff said they trusted the local leadership teams and mostly felt able to raise concerns with them. Staff fully recognised the impact of the COVID-19 pandemic and most staff had felt supported throughout this time by leaders. Almost all staff told us they felt respected and valued by their colleagues and the leadership team within the trust. There was a strong sense of teamwork which encouraged candour, openness and honesty. Staff told us the support they had received from their colleagues in the service helped them cope with the pressures which sometimes arose when they became very busy. The culture within the service was usually centred on the needs and experience of patients, but leaders were fully aware of the changes required in responding to the COVID-19 pandemic had impacted on service delivery and staff morale. Staff said they felt 'tired'. When something went wrong, people received a sincere apology and were told about any actions to prevent something similar happening in the future. Most staff told us the service operated in an open, friendly and inclusive manner. There was usually a 'no-blame' approach used with respect to complaints, incidents, and errors. They all told us they enjoyed working there. We saw positive professional interactions between staff in the service and mostly effective communication with patients. Staff were proud of their hospital and described it as having a 'family feel'.

Medical care (including older people's care)

Local leaders gave an effective and brief overview of the changes that Good Hope Hospital management team had made during the pandemic and plans for the future. The plans appeared far reaching and were presented with much enthusiasm and pride. The warmth from these leaders for the staff and the community at large was evident. Trust wide initiatives were in place to recognise individual and collective team successes and we were provided with examples of where staff on ward 12 and the frailty assessment unit had been recognised.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A governance system was in place with the production of detailed information about the division's performance, which was discussed at regular governance meetings and used to demonstrate effectiveness and progress across the service. Each division reported key quality, safety and performance metrics in quarterly clinical governance and patient safety reports. Each specialty produced a specific quarterly clinical governance and patient safety report, detailing key quality, safety and performance metrics. These were discussed at the specialty management meetings. Key actions and areas of excellence were identified. Based on the records we reviewed, investigation and identification of learning from serious incidents was effective. Clear actions had been put in place. Staff told us how this learning was shared at ward huddle meetings.

We reviewed a sample of divisional board meeting minutes from February to May 2021. The meetings were well attended by the relevant leaders and they contained information and risks for specialties with actions articulated to mitigate them.

Minutes described the performance and safety issues for each division and specialty clearly and any actions required to improve the service were identified appropriately. Local leaders confirmed that key messages were cascaded throughout staff teams. Each division also held monthly quality and safety meetings and we saw the key themes arising from these were reported and escalated as appropriate to the divisional board meeting.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders were aware of the risks we found on inspection, notably the staffing pressures particularly pronounced on the health care of older people wards. Longer term plans to improve services were in place, but at the time of the inspection, these outcomes had not yet been delivered. Divisions maintained appropriate risk registers, which defined the severity and likelihood of risks in their services causing potential harm to patients or staff. They documented the measures to be taken to reduce the risk. We saw the risks reflected the concerns described by staff in the service. Staff knew how to report and escalate risks. Staff said the risk registers were reviewed frequently by the leadership team and severe risks were escalated to the corporate risk register and board when necessary. Each division reviewed its performance against the trust's quality assurance dashboard monthly and we saw the key themes arising from these were reported and escalated as appropriate to the divisional board meeting.

Medical care (including older people's care)

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. Data or notifications were consistently submitted to external organisations as required.

Staff received helpful data on a regular basis, which supported them to adjust and improve performance as necessary. Staff generally had access to up-to-date, accurate, and comprehensive information on patients' care and treatment. Staff were aware of how to use and store confidential information. Notifications were made to external organisations when required although staff said this had been impacted by the COVID-19 pandemic.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust wide leadership team engaged with staff and aimed to ensure their voices were heard and acted on to shape services and culture. The medical care service gathered feedback from staff through a variety of forums and methods. Almost all staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and managers. There had been frequent staff engagement sessions at Good Hope Hospital with the trust's chief nurse and deputies.

The quarterly staff friends and family test was a regular measure of staff experience, which was monitored at hospital level. Improvements in scores were seen during the last 12 months, with changes across the year reflecting the challenges and experiences of staff working throughout the pandemic. The quarter four score (March 21 survey) for Good Hope Hospital for the question 'would you recommend this hospital as a place to work' was up by 7% to 65%, which was the highest in the last 12 months.

Views and experiences of patients and those close to them were gathered and acted on to shape and improve the service. The patient experience team reported patient feedback and engagement results by hospital, division, ward and specialty across a range of forums. The data provided was not specifically broken down into medical care wards. Patient feedback had continued to be collected during the pandemic. The main patient engagement activity through the trust's patient, carer and community councils (PCCC) was site based, and included some mention of medical care wards, this depended on issues that patients raised or planned work such as PLACE reviews into these areas. Engagement also took place with community groups and/or was based on specific issues that have been identified.

PLACE assessments had been paused during the pandemic. Before this, the trust participated in the national PLACE assessments, ensuring patient engagement was part of the team make up and assessment process in line with guidance. Results were reported back to the PCCCs along with any actions being taken.

Back to the floor visits (BTTF) visits were led by each division across the trust and were restarting following the main waves of the pandemic. The visiting panel were senior staff from across the trust that came from a variety of backgrounds including patient experience, education, health and safety, nursing and bereavement. The findings were fed back locally to the senior sister/ward manager, matron, deputy and directors of nursing.

Medical care (including older people's care)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had an understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research wherever possible.

In response to the COVID-19 pandemic, there had been a number of reconfigurations of patient pathways and ward locations to improve patient care and safety. There had also been a number of trust wide improvement initiatives including 'Letters for loved ones' which commenced in April 2020 as a direct response to the impact on the COVID-19 pandemic on patients and their carers to promote effective communication.

Following the last inspection, the trust had taken action to address the issues identified on ward 8, which included a reduction in two beds to mitigate staffing levels and an increase in the number of daily senior nurse ward visits including weekends.

Since the last inspection, we saw as part of a deep dive undertaken on ward 8, two surveys were designed, one for patients and another for the staff to complete. Overall, the surveys illustrated that patient opinion regarding care was more positive than staff experienced, but both indicated staffing levels needed consideration and review, which would impact upon any other key issues raised by the survey.

The deputy head of patient experience was leading a quality improvement (QI) group around communication and how this could be improved. The first meeting was held in April 2021 and involved a broad cross-section of staff and patient carer council members. A discharge group QI was being led by the deputy director patient experience to review all aspects of discharge and identify opportunities for improvement.

Urgent and emergency services

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff but did not always make sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. According to data supplied by the trust, nursing staff had completed on average 94.6% of their mandatory training.

Medical staff received but did not always keep up-to-date with their mandatory training. According to data supplied by the trust, medical staff had completed on average 79.2% of their mandatory training. According to the data, 57.1% of medical staff had completed the following three training modules; fire safety, information governance and health, safety and welfare. The mandatory training target from staff was 95%. Mandatory training levels were worse due to the Covid-19 outbreak.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed a mix of both face to face and online training. Staff told us that the mandatory training met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients living with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a system which would flag up a staff member who was overdue on a mandatory training module.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have training on how to recognise and report abuse however they knew how to apply safeguarding processes.

Nursing staff received training specific for their role on how to recognise and report abuse. According to data supplied by the trust, nursing staff had appropriate levels training in safeguarding specific to their roles.

Medical staff mostly received training specific for their role on how to recognise and report abuse. According to data supplied by the trust, 76% of medical staff had completed level two safeguarding training. The shortfall related to junior doctors due to them not completing the trusts clinical induction due to the pandemic. The trust told us these staff were emailed quarterly.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Policies for the protection of adults and children were in place. They

supported staff to identify different types of abuse and provided guidance on the provider's policies and procedures. Guidance supported staff to report abuse to external organisations such as the local safeguarding authority who could take action to investigate concerns. There was reference to local and national guidance and the legal responsibilities for staff.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to demonstrate how they would make a safeguarding referral. Staff knew how to contact the safeguarding team if they needed advice. The safeguarding team remained on site throughout the pandemic and continued to offer advice and support.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Children went to a specific area of the emergency department (ED). The children's liaison service reviewed all child attendances from ED. Guidance for clinical staff involved in virtual assessments had been developed to minimise risks to children.

Staff followed safe procedures for children visiting the department. Children attending the department were directed towards the children's accident and emergency department. Children would not have been attending as visitors due to the visitor restrictions in place.

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.

All areas were clean and had suitable furnishings which were clean and well-maintained. On inspection, we saw all areas of the ED were clean. We saw staff continuously cleaning the departments throughout the visit. Staff cleaned rooms after use before a new patient would use them. Furnishings were clean and well maintained. The service generally performed well for cleanliness.

Cleaning records were up-to-date and demonstrated all areas were cleaned regularly. The trust had a cleaning roster and signed signature sheets for each area of the department which were completed appropriately.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were seen following good hand hygiene practices and washed their hands when moving between patients. There was PPE and hand gel available at all entrances of the department and staff were observed changing masks and cleaning using the hand gel. There was appropriate signage in place indicating which PPE staff needed to wear before they entered a specific area or room, including rooms where aerosol generating procedures (AGPs) were taking place. The service had an appropriate room for donning and doffing PPE. We observed staff mostly using appropriate PPE during the inspection process. There was one occasion when we observed two staff members not wearing masks appropriately in a clinical area.

The trust audited IPC practices regularly. According to data supplied by the trust, the trust had performed at or above 90% each month in hand hygiene, environment and catheter audits in each of the last six months apart from on three occasions. The environment audits in February and April 2021 were 82% and 75% respectively. The hand hygiene audit in February 2021 was 75%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment after use before a new patient would use them. Equipment had 'I am clean' labels on when staff had cleaned it.

Urgent and emergency services

Environment and equipment

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 and staff responded quickly when called.

The design of the environment mostly followed national guidance. The service had a room specifically for mental health patients in the majors department. The room was mostly suitable and had closed-circuit television (CCTV) in the room. The service was not ligature risk free as the ceiling tiles were movable. Following the inspection, the estates team were working on making adjustments to ensure it was fit for purpose, although we have not returned to see the improvements planned.

Staff carried out daily safety checks of specialist equipment. In the records we observed, staff had consistently carried out daily checks of all necessary equipment. Equipment across the department had in date electronic testing. If equipment was broken it was labelled and reported to clinical engineering.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to clinical equipment appropriate to each clinical area. Staff had access to the appropriate resuscitation trolleys across the department.

Staff disposed of clinical waste safely. Bins across the department were clearly labelled in all areas. We observed staff disposing of waste appropriately whilst on site.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff carried out national early warning scores 2 (NEWS2) and paediatric early warning scores (PEWS) risk assessments on patients, we saw these had been carried out in patients' records. Staff carried out regular observations on patients in the waiting area and went and spoke to patients in the queue outside and prioritised patients most at risk.

Staff completed risk assessments for each patient on arrival as a walk-in patient, using a recognised tool, and reviewed this regularly, including after any incident. In the records we reviewed we saw staff had undertaken appropriate risk assessments. The trust had created Point of Care Testing (POCT) laboratories within the ED/AMU areas at Queen Elizabeth Hospital Birmingham, Birmingham Heartlands Hospital and Good Hope Hospital. This was to ensure all patients being admitted to the trust were screened on admission.

Staff knew about and dealt with any specific risk issues. Staff had a good knowledge of sepsis. We observed good compliance with National Institute of Health and Care Excellence (NICE) on sepsis. Staff had access to mattresses to help patients who were at risk of pressure ulcers.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During the doctor's handover, we observed psychological risk assessments had been considered and actioned for all patients believed to be at risk. We reviewed the records of two patients living with mental health needs and saw that psychological assessments had been arranged.

Staff shared key information to keep patients safe when handing over their care to others. Staff ensured they did a handover of patients' information when patients were moving to a different area of the hospital.

Shift changes and handovers included all necessary key information to keep patients safe. The service had both a nursing and medical handover between each of the shifts. We observed both a nursing and medical handover and they were well attended, and all the key information was shared.

Nurse staffing

The service had enough nursing 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 bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Whilst the service did have high vacancy rates, whilst on inspection and looking at staffing rotas we saw that the planned staffing levels and skill mix was high enough to ensure patients were kept safe.

The service had two portering staff across the whole department. Staff told us this caused significant delays to transporting patients to different areas of the hospital. Whilst on site we observed staff calling for porters for over half an hour before they had time to attend.

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. Rotas were completed and reviewed regularly by a senior staff member and there was always assurance staffing levels met national guidance.

The department manager could adjust staffing levels daily according to the needs of patients. Matrons and divisional directors of nursing monitored staffing levels across the site, there was a meeting at a minimum twice daily to review all staffing on all areas and move staff to minimise risk. Redeployment of staff across all areas of the trust was carried out and coordinated by divisional teams.

The number of nurses and healthcare assistants matched the planned numbers. Staff told us they were sometimes short staffed due to sickness, but managers worked to bring in additional bank or agency staff in order to keep staff numbers at a safe level.

The children department was staffed by staffed by at least two registered children's nurses at all times.

The service had high vacancy rates for band five nursing staff. According to data supplied by the trust, the service currently had vacancies for 13.21 whole time equivalent (WTE) qualified nursing staff members. At the time of inspection, the service had eight nursing staff members awaiting to start. The service also had a rolling recruitment in place for nursing staff.

Urgent and emergency services

The service had high turnover rates. According to data supplied by the trust, between May 2020 and April 2021 the service had a turnover of 4.7% for qualified nursing staff and 10.3% for unqualified nursing staff.

The service had average sickness rates. According to data supplied by the trust, between November 2020 and April 2021 there was on average 7.9% for nursing staff, with a spike of 11.6% in December 2020.

The service had high rates of bank and agency nurses. According to data received by the trust, between December 2020 and June 2021, 1,040 shifts had been covered by bank staff and 3,341 shifts had been covered by agency staff across all non-paediatric areas of the department. In the paediatric department 131 shifts had been covered by bank staff and three shifts had been covered by agency staff.

Managers could not limit their use of bank and agency staff but requested staff familiar with the service. Staff needed to use high levels of agency staff in order to ensure safer staffing levels across the departments. Staff used regular agency staff and at the time of inspection had block booked agency staff members. Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service 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. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Most medical staff rotated with staff from Birmingham Heartlands Hospital.

The medical staff matched the planned number. Whilst on inspection we saw the number of medical staff matched the planned number. Medical staff told us sometimes they were short staffed on nights, however they felt they had enough staff members to keep patients safe.

The children's department was staff by at least one paediatric medicine consultant at all times.

The service had high vacancy rates for junior medical staff. According to data supplied by the trust, the current vacancies were for seven whole time equivalent junior medical staff.

The service had low turnover rates for medical staff. According to data supplied by the trust, between May 2020 and April 2021 the service had no turnover of senior medics. Data was not supplied by the trust regarding junior medical staff.

Sickness rates for medical staff were low. According to data supplied by the trust, between November 2020 and April 2021 there was on average 0.1% staff sickness amongst medical staff.

The service had high rates of bank and locum staff. According to data supplied by the trust the service used 6,378.2 hours of bank cover and 12,725.3 hours of agency cover between December 2020 and June 2021. Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. Locum staff we spoke with said they had a full induction with the trust and most locum staff we spoke with were regular staff members.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Urgent and emergency services

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. Records were not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. Most patient notes were in paper form and kept near the patients. Records we reviewed were clear and up-to-date.

When patients transferred to a new team, there were no delays in staff accessing their records. When patients left ED, a copy was scanned into the system, following this the patients notes moved with them to the new department or were stored appropriately if discharged.

Managers of the department carried out daily spot checks in the department to ensure all records are accurate, complete and detailed. During these checks the senior team ensured all records were complete, legible, indelible, accurate and up to date, with no undue delays in adding information.

Records were not always stored securely.

Medicines

The service did not use systems and processes to safely store and manage medicines. However, the service used systems and processes to safely administer, record and prescribe medicines.

Medicines were not stored safely in line with good practice or trust policies. During the inspection we identified poor storage of medicines with overcrowded and untidy cupboards. During the inspection we saw loose blister strips of medicines in cupboards, we also saw loose ampoules of medicines which should similarly be kept in their original packaging. This was not in line with the trusts medicines management policy or national guidance. There were also out of date items available for use, in the providers medicines management policy it stated, 'it is good practice to check product expiry dates at least once a month'. There were also concerns around the security of medicines in minors. The treatment room was open to a corridor where patients were seated and where nurses based at the nurses station did not have line of sight. There was a recently delivered pharmacy bag left on the table in the unlocked room which was accessible to patients without staff being aware.

Staff were not following national guidance or trust policy in the monitoring of fridge items or responding to temperatures outside of the recommended ranges. Staff were not consistently monitoring fridge temperatures in line with the medicines management policy. When the temperatures were seen to be out of range, which they were on some records, this was not actioned. The service could not be sure that medicines remained safe and effective.

There was no clinical pharmacy service to the unit. As a result of this, there was no service to ensure sufficient stock in each area. It also meant there was a lack pharmacy oversight on the unit and this contributed to the current medicines' management situation across the department. Staff told us historical problems with medicines 'loss' and stock levels had prompted a visit from the trust pharmacy team six weeks before the inspection where it was identified there were significant problems with medicines storage, stock levels and poor adherence with trust medicine management policies. Actions included a review of stock levels in all areas and provision of a pharmacy technician to support medicines management in the ED department. These actions had not occurred at the time of our inspection.

Urgent and emergency services

Between June 2020 and May 2021 there were 12 incidents identified which were attributed to the issues identified with medicines management in the department. The breakdown of incidents was identified as; five incidents of no medicine stock in the department, three incidents where incorrect medicines were given, one incident where they were unable to find medicines, one incident with incorrect stock levels, one incident where wrong medicines were recorded and one incident of incorrect medicines being prepared.

The service had systems and processes in place to safely administer and record medicines use. There were systems and processes in place to ensure medicines were administered and recorded. We observed medicines being administered correctly and saw evidence that medicine administration was recorded appropriately in patients notes. Staff told us the trust intranet system was used to disseminate safety information; we saw evidence of a publication 'Risky Business' being produced. Lessons learnt from incidents reported through the nursing team were shared with all Good Hope Hospital nurses but were not shared with all Urgent and Emergency Care departments in the trust. Incidents reported by the consultants were shared trust wide.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We reviewed patients records and staff reviewed patients' medicines regularly and provided specific advice to patients.

Incidents

The service managed patient safety incidents well. Staff recognised and reported 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. Throughout the inspection, managers and ED staff were able to demonstrate they knew what types of incidents to report and how to do so. Staff across the whole service knew who to escalate incidents to and all staff had access to the incident reporting system. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had no never events.

Across the service, there had been 139 incidents which had resulted in harm, two of these incidents occurred in the paediatric ED. The highest number of incidents occurred in the following categories; there were 19 incidents of pressure ulcers, 19 incidents of patient falls, 17 incidents of non-adherence to standards, 16 incidents of admissions, discharge and 10 incidents relating to medication.

Managers shared learning with their staff about never events that happened elsewhere. Staff discussed learning from incidents at staff meetings. The service had a communications folder which was placed in the staff room where learning from incidents was shared.

Staff reported serious incidents clearly and in line with trust policy.

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. Staff carried out duty of candour in line with the trusts policy. The service would ensure families were initially contacted by telephone, then in writing.

Urgent and emergency services

Staff received feedback from investigation of incidents, both internal and external to the service, but not always in relation to medicines incidents.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. We reviewed two serious incident investigations which included evidence of changes being made. For example, following on from one patient fall, managers met to discuss a standardised process for assessment and provision of walking aids in ED.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers completed a root cause analysis (RCA) to determine how and why a patient safety incident had occurred. Root causes are the fundamental issues that led to the occurrence of an incident and can be identified using a systematic approach to investigation. Contributory factors related to the incident may also be identified. We reviewed the previous three RCA's completed by the service. They identified areas for change and developed recommendations, with the aim of providing safe patient care. Involvement and support for patients and relatives formed part of the RCA process.

Managers debriefed and supported staff after any serious incident.

There was a process in place to share any learning from the outcome of investigations within the organisation and with other stakeholders when appropriate. Outcomes of investigations were monitored to identify any trends and themes.

Safety Thermometer

There was no safety thermometer data available for the ED department as this national tool was designed to audit and monitor the quality of care in inpatient areas.

Is the service effective?

Good

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

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 up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We observed staff following best practice guidance when following up patients with potential sepsis. Nurses carrying out triage assessments had completed training and competencies in the use of the Manchester triage system. This ensured they worked to evidence-based, national guidance. We observed this in practice and nurses demonstrated strict adherence to the system including documentation of allergies, medical history and current condition and vital signs.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. We observed both medical and nursing handovers where patients psychological and emotional needs were discussed.

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. We observed patients receiving food regularly at mealtimes, as well as food and drink being provided when requested.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff had access to fluid and hydration charts in the departments and used them where necessary.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff knew how to make referrals to therapists if they were needed. These would mostly be utilised once patients moved to another area of the hospital.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools 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. We observed staff assessing patients' pain at regular intervals and saw evidence of this in patients' records.

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed patients getting pain relief when it was requested.

Staff prescribed, administered and recorded pain relief accurately. We saw evidence of this in the patient records we observed.

Patient outcomes.

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved varied outcomes for patients.

The service participated in relevant national clinical audits. This included the Royal College of Emergency Medicine (RCEM) moderate and acute severe asthma audit.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards. The service participated in RCEM audits during 2019/20 which included care of children, mental health (self-harm) and assessing for cognitive impairment in older people.

In the care of children audit, the service met the national standards for four of the measures, however they did not meet the national standards for two of the outcomes. For standard two 'A review of the notes is undertaken by a senior

clinician when an infant, child or adolescent leaves or is removed from the department without being seen', the service carried out the review on two out of 26 occasions. In the mental health (self-harm) audit the service was slightly below the national average in all three of the standards. In the cognitive impairment in older people audit, the service was above national average for two of the standards and below the national average on one occasion.

Managers and staff used the results to improve patients' outcomes. The service used the outcomes measured and had recommendations as part of the RCEM audits. These improvements included a radical change in reviewing children's notes when they left without being seen, installing an area in ED where a patient could be observed and a cognitive assessment of patients over 75 years old using a validated tool whilst in the ED.

The trust participated in outcome measured projects during 2020/21, however at the time of inspection the results were pending.

Managers and staff planned to resume carrying out a comprehensive programme of repeated audits to check improvement over time. Many audits had been paused during the pandemic, but these had recently resumed or were resuming. The staff had continued to carry out audits around infection prevention within the department. Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored.

Managers used information from the audits to improve care and treatment. Action plans were put in place following all the clinical audits we reviewed.

The emergency medicine team had identified quality improvement programmes (QIPs) focused on the Emergency Medicine curriculum changes for 2021.

We requested information about investigating outliers but did not receive any information related to outliers.

The service had a lower than expected risk of re-attendance than the England average. According to data received by the trust, between 1 June 2020 and the 31 May 2021 the service had a re-attendance rate within seven days of 5.3%.

Competent staff

Although the service made sure staff were qualified and had the right skills, ongoing competency was harder to ascertain. Staff's work performance was not appraised due to the COVID-19 pandemic, although plans were in place to address this.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. However, there was a lack of continuous professional development for nursing staff within the department.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us and managers were able to demonstrate that all staff had a fully tailored induction for each role.

Managers tried to support staff to develop through yearly, constructive appraisals of their work, however appraisals had been paused during the pandemic. The trust told us five (7%) nursing staff and 15 (37%) non-clinical staff in the emergency department had received their appraisals as planned. Nine non-trainee doctors (41%) had completed appraisals as planned.

Managers at the service were using a band seven member of staff who was working from home to help carry out appraisals of nursing staff.

Appraisals were suspended during the pandemic and all appraisal training was paused. The trust had since started to increase communications around appraisals and linking the appraisal conversation to wellbeing to support staff. The trust's medical appraisal process restarted in April 2021. The trust stated they recognised appraisals provided doctors with a much-needed source of support, offering them an opportunity to focus on their wellbeing and reflect on their experiences. Periodic communications to non-trainee medical staff had been issued including how they would be supported with revalidation and appraisal. The chief medical officer's team worked with the assistant medical director to support non-trainee medical staff with their appraisals.

The clinical educators supported the learning and development needs of staff. Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Senior medics told us they provided clinical supervision to their junior staff members.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us they attended team meetings where possible and notes were available to staff who could not attend team meetings by email.

Managers did not always identify any training needs their staff had and staff did not always have the opportunity to develop their skills and knowledge. The service did not have a full-time professional development nurse as they had to share one with the other two sites. A professional development nurse organises training and ED study days. Managers told us they found it difficult to maintain a good standard of training because of this. Staff felt this was having an impact on the services ability to retain nursing staff.

Managers identified poor staff performance promptly and supported staff to improve.

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. Staff held meetings involving different members of staff where all the patients' needs were discussed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff at all levels and from all disciplines worked together to deliver person centred and coordinated care and support for the person with care needs. Patients in the majors C department of the hospital had access to physio and occupational therapist support if it was required.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. We observed staff referring patients for psychological assessments when they showed signs of 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.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on within the department.

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 limited patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records and records we reviewed confirmed this.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff who worked in the children's ED department had a clear understanding of what Gillick competence meant.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of inspection, 87% of nursing staff had undertaken training in Mental Capacity Act and Deprivation of Liberty Safeguards.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of inspection, 85% of clinical staff had undertaken training in Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The trust also had a mental health compliance team which included two Mental Health Act Administrators who ensure the trust complied with the legal framework.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy documents and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Policies were in place to support staff to identify and take appropriate action when it was necessary to seek authorisation to deprive a patient of their liberty. The policy required staff to review a patient's mental capacity and identify the use of the most least restrictive options in line with their legal duties. Staff had access to onsite safeguarding leads and an electronic system to raise DoLS applications with the local authority.

Urgent and emergency services

Is the service caring?

Good

Our rating of the service 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. We observed staff interacting with patients as much as possible and staff were responsive to patients needs and responded as quickly as they could.

Patients said staff treated them well and with kindness. All patients we spoke with told us staff treated them with kindness. Throughout the inspection we observed patients being treated with kindness.

Staff did not always follow policy to keep patient care and treatment confidential. Staff maintained confidentiality as much as possible in the circumstances however, it was difficult to maintain patient confidentiality when patients were discussing issues in the queue of a busy waiting room or in a queue outside the hospital entrance. Staff were discussing potentially sensitive information which other people would be able to hear. Staff who worked behind reception also had difficulty hearing patients who they were speaking to through the intercom system, so patients often had to repeat information loudly.

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.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

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. We saw staff providing emotional support and discussing patients' wellbeing in all areas of the department. Members of the chaplaincy team also visited patients in departments, providing spiritual care as requested by patients and families.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. If patients became upset or distressed in the waiting area staff always approached them to provide support. It was difficult to help patients maintain privacy and dignity due to lack of space as a result of social distancing and how busy the waiting area was.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Urgent and emergency services

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 saw staff engage with relatives in an empathetic way, particularly when explaining to them that they were not allowed to remain in the department due to COVID-19 visitor restrictions.

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 took the time to explain patients care and treatment to them when it was possible.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were signs around the department which explained how patients and relatives could leave feedback.

Staff mostly supported patients to make informed decisions about their care. However, there was a poor understanding amongst staff of Accessible Information Standards (AIS), so patient who required additional help with communication may not have been as engaged in making informed decisions.

Is the service responsive?

Requires Improvement

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

Service delivery to meet the needs of local people

The service did not plan and provide care in a way that met the needs of local people and the communities served. It did not always work with others effectively in the wider system and local organisations to plan care.

Managers did not plan and organise services, so they met the needs of the local population. Staff in the department raised significant concerns about access to, and the effectiveness of community based urgent care centres and auxiliary services used to support urgent and emergency care. Attendances to the ED at Good Hope Hospital were reported to be increasing week on week, with demand outstripping capacity daily. There was a lack of a system wide approach and leaders did not work effectively with local healthcare partners, such as GP services, to improve the service offered to patients. There was little insight from the local divisional team as to the deliverables of the local accident and emergency delivery board. It was reported this was chaired by the trust chief executive but there was no formal representation or membership from front-line clinicians or the divisional team. It was therefore not clear what the local strategy was in terms of educating the public as to accessing urgent and emergency care provision.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Urgent and emergency services

Facilities and premises were mostly appropriate for the services being delivered. However, due to lack of space in the reception area and the effects of the pandemic patients were forced to wait to wait outside the department. Patients were regularly observed whilst waiting outside.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients living with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. Alerts were on electronic records. This highlighted additional patient needs such as frequent attenders, patients living with mental health, learning disabilities and physical disabilities and patients with aggressive behaviours.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences.

Staff did not always understand and apply the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was a poor understanding of how to access interpreters when needed. There was a lack of understanding of Accessible information standard (AIS). The trust had undertaken serious incident reviews into cases where patients had sensory disabilities and/or specific communication requirements, for example as a result of a learning disability which impaired speech. These reports highlighted a lack of staff understanding as to how to support patients effectively, and in line with the AIS, in terms of alternative communication provision so patients were fully involved in their care and treatment.

Staff had access to a vulnerabilities team to support patients if needed. Staff undertook appropriate referrals to specialist teams. The vulnerabilities team, with nursing specialisms in learning disability, autism, mental health, and dementia and delirium, initially focussed on patients with a learning disability and autism, and more latterly mental health. Staff allowed one visitor to be with a patient if they were considered vulnerable. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The service did not have information leaflets available in languages spoken by the patients and local community. Staff at the service did not have access to leaflets for patients who spoke languages other than English.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when need. Staff at the service had access to language line if needed. Staff told us they would use a translation app if they needed information quickly and the patient did not speak English.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not access the service when they needed it and did not receive the right care promptly. 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. Patients could not always access emergency services when needed and did not always receive treatment within agreed timeframes and national targets. According to data supplied by the trust, between 1 March and 31 May 2021 the service breached the one-hour ambulance waits outside of the department 379

times. This included 229 breaches in May 2021. Whilst on inspection, we saw at one time there were 20 ambulances waiting outside the department, with nine ambulances breaching the one hour wait time. The target time for patients to be admitted following arrival on an ambulance was 15 minutes. Staff were attempting to find beds within the hospital in order to move patients through the department.

Meetings held on the site were not always effective. There was a lack of forward planning and actions taken in dealing with bed and exit blocking. There were bed meetings held to discuss capacity in the hospital at 8am, 12pm and 3pm which was attended by the site team and staff from departments across the hospital, including ED. In the bed meeting we observed the current situation was discussed, including both ambulance delays, majors bed capacity and potential discharges. There was a lack of future planning and a lack of actions proposed that would be put in place to remove some of the pressure on the ED.

Patients were often queuing outside the walk-in entrance of the department due to a lack of space and social distancing within the waiting room. The service had a navigation nurse and an ambulance nurse who were responsible for booking both walk-in patients and ambulance arrivals respectively. ED staff escalated patients who were awaiting beds in the hospital but could not be moved due bed space.

Managers tried to work to make sure patients did not stay longer than they needed to, however this was not possible due to a lack of flow through the hospital and exit block of the beds throughout the wards in the rest of the hospital. According to data supplied by the trust, between 1 March and 31 May 2021 the service achieved on average 73.2% performance against the four-hour target to treat, admit or transfer a patient from when they arrived at the department. The national target was 95%, although for April to June 2021 the average for all trusts was 76%. There were also five patients who breached 12 hours waiting to be treated, admitted or transferred from when they arrived in the department.

Staff worked to make sure they started discharge planning as early as possible. Staff within the ED planned discharges for patients who were suitable as soon as it was possible. Staff could not always move patients into other wards within the hospital due to a lack of bed space.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Staff supported patients when they were referred or transferred between services.

The service moved patients only when there was a clear medical reason or in their best interest.

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. Patients we spoke with told us they knew how to complain and would do so without fear.

The service clearly displayed information about how to raise a concern in patient areas. There was signage all over the department which advised patients on how to make a complaint or raise concerns if they needed to.

Staff understood the policy on complaints and knew how to handle them. Staff within the service understood the complaints procedure and were able to give advice to patients on the process if they wished to make a formal complaint to the trust.

Managers investigated complaints and identified themes. The department had identified staff members who investigated complaints when they were received. The service also identified themes from complaints. According to data received by the trust, between June 2020 and May 2021 there were 44 formal complaints received by the service. The main themes identified were communication with relatives/carers (12) and delay in clinical care/treatment (10). Complaint themes were discussed as a regular item in the quality and safety meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers would share feedback from complaints with the individuals involved and the wider team.

Is the service well-led?

Requires Improvement

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

Leadership

Leaders did not always have the skills and abilities to run the service. They understood but did not effectively manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

Department leaders had the skills and ability to run the service, however the triumvirate senior leadership team were new in post and still familiarising themselves with the priorities. Local leaders had high standards of patient care and safety. Most staff we spoke with said they considered local department leadership and management teams to be accessible, responsive and supportive.

The service had a triumvirate senior leadership structure which included a clinical director, divisional head of nursing and a general manager who led the service. However, most staff said they rarely saw senior staff above matron level. The triumvirate senior leadership team were relatively new in post. We raised concerns about the extensive number of patients who were held on ambulances. Clinical oversight of these patients was extremely ambiguous. Whilst the trust reported they accepted the clinical responsibility of the patients, they reported there were arrangements in place with the NHS ambulance service for their staff to monitor and escalate patients to the relevant nurse as required. As part of the inspection we approached the NHS ambulance service who subsequently reported that no such formal process was in place.

Staff felt disconnected from the trust leadership and executive team and they felt the executive team did not understand what was happening on the site. Staff said they rarely saw members of the executive team and they felt disconnected from the overall trust management.

Urgent and emergency services

Whilst trust and site leaders understood the challenges the service faced in terms of exit blocking and patient flow throughout the department, they did not manage the priorities in a way which reduced pressure and assisted staff treating patients within the department.

Vision and Strategy

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

The service had a strategy in place for the service, covering the ED departments across all hospital sites. The ED strategy was to deliver 'Right person; Right place; Right time'.

The service had urgent and emergency care priorities that it was working towards with a system wide approach on which included consideration for; additional demand – effects of post lockdown, complex and minor cases, workforce challenges (annual leave/retention), paediatric viruses, COVID-19 variants and the flu.

Staff felt with the demand for emergency care steadily increasing year-on-year the situation of overcrowding, delays in ambulance handovers and risks associated with patient flow would only get worse unless there was a whole system approach to planning for and managing heightened demand.

Culture

Staff did not feel respected, supported and valued. Most staff focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns. Staff did not always feel safe when working in the department.

Staff did not always feel respected, supported and valued by the site and senior leadership teams. Staff felt a lack of support from the site team and staff felt they were blamed and put under pressure to provide care in a way which they deemed to be unsafe. However, staff felt well supported by local leaders within the department. Junior medical staff felt well supported by senior medical staff within the department.

Staff within the ED team were focused on the needs of patients within the department receiving good, safe care. Staff focused on patients' mental health needs as well as physical needs, this was evident in patient handovers and within patient records.

There was a poor culture from the site leadership which was negatively impacting staff in the ED. Whilst on inspection we observed conflict between the site team and the staff within ED. The site team were trying to pressure ED staff to nurse patients within the corridors in the majors department, however the ED staff felt it was not safe to do so. The ED staff explained that there were no patients suitable for corridor nursing and that corridor care in general was not safe for patients however the site team continued to apply pressure and claimed other ED departments were corridor nursing patients across the trust. These discussions happened in view of patients and visitors. This pressure to care for patient in the corridors happened throughout the day, the nurse in charge received phone calls consistently being asked to nurse patients on the corridor. There was no standard operating procedure to support this decision making. Staff told us they felt there was a blame culture coming from outside into the ED department.

The service introduced schemes which supported staff wellbeing. The service set up a staff wellbeing hub on the site. The service also had a member of staff who was based mainly in the staff room who was there for staff to talk to and to provide drinks for staff. Staff also had access to counselling services and other support through the trust intranet and the wellbeing staff member had leaflets available if staff needed extra support.

Staff did not always feel safe throughout the department. The service had security staff at the entrance to the department to protect both patients and staff. The security staff ensured patients followed infection prevention control practices and were the first contact for patients. Staff in the minors unit felt unsafe, particularly at night time. The minors unit was separate from the rest of the unit and had been moved several times during the pandemic. There were often two staff members working in the department and they were isolated from the rest of the ED. Staff could work alone for a short period of time if one member had to leave temporarily. There was no CCTV in the corridor and staff had no way to immediately alert the rest of the hospital if there was an emergency. Staff had access to personal alarms, however this would only alert other staff members in the unit if there was an issue and not anyone in the wider hospital.

Staff in the majors department told us they were regularly abused by patients and these types of incidents were increasing. Whilst staff had personal alarms and there was a member of security staff at the main entrance, staff still felt at risk. Staff had no additional training in conflict resolution or breakaway techniques which could help to de-escalate situations or prevent injury.

Healthcare assistants were expected to undertake one to one patient monitoring of potentially violent and aggressive patients. Staff told us they felt vulnerable at times. Staff carrying out these assessments did not have any formal training to make them feel safer.

Patients felt they could raise concerns without fear. Patients we spoke with told us they would raise concerns without any fear of victimisation, and they felt that their concerns would be listened to by staff in the department. However, staff felt that these concerns would not necessarily be acted on by the senior leadership team.

Governance

Leaders mostly operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear governance structure. Good Hope Hospital ED formed part of the wider ED group which incorporated the emergency departments from the other hospitals which formed University Hospitals Birmingham NHS Foundation Trust. The emergency division directorate had a triumvirate leadership consisting of a clinical director, divisional head of nursing and a general manager. The ED directorate formed part of division three alongside other acute medical services. The service was managed on a day to day basis by a matron or nurse in charge if the matron was not available. Staff were clear about their roles and accountabilities and where they fitted into the governance structure.

There were opportunities to meet, discuss and learn from the performance of the service. As part of the inspection process we requested minutes from divisional and ED governance meetings over the last six months. In the ED division clinical governance meeting there was a discussion of incidents, the risk register and any audits that had been undertaken. In the division three quality and safety meeting minutes, a report on emergency medicine highlighted the main areas of concern discussed. There was evidence that issues relating to ambulance handover times were also discussed in the governance section of the meeting. The risk register for the division, including EDs risks were also discussed. These meetings were well attended by staff across the service. We reviewed the minutes from the divisional

ED department meetings. In this meeting the individual ED got to discuss specific updates which were happening at their site. These were discussed along with specific risks and incidents. There was also an opportunity for nurses and junior doctors the give feedback, as well as specific sections for children's ED and areas such as minors. This meeting included an action log which was updated each month.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They identified some risks but did not escalate relevant risks and issues and did not always identify actions to reduce their impact. Staff did not always contribute to decision-making.

Leaders did not use systems to manage risks effectively. Leaders at the service focussed risk on the ED rather than spreading the risk throughout the hospital. The site team concentrated the risk in ED rather than taking a whole hospital approach to risk in order to relieve some of the pressure on ED and the staff. There was no consideration of the risk to patients of corridor nursing several patients within the department with no extra staff members. Risks of corridor nursing included difficulty of administering urgent intravenous antibiotics, lack of access to toilet facilities for patients, lack of privacy and dignity, and increased distress for patients, particularly those with mental health problems. There was a lack of systems and processes in place to enable corridor nursing to be done safely.

Staff within the department did not have a ratified standard operating procedure for corridor nursing at the time of inspection, they had a list of criteria. The site team were pressuring the ED staff to nurse patients on the corridor who did not meet the criteria which had been set. This issue was not on the sites local risk register.

As part of the inspection process the trust provided us with a 'Health and Safety/Fire assessment' dated 19 May 2021, this was the only risk assessment provided in relation to nursing patients in corridors. The outcome of the risk assessment undertaken by a fire safety advisor and a health and safety advisor was, 'As the proposed plan to treat patients in corridors not only contravenes the fire regulations, it will also cause the patients to be put at a much greater risk in a fire situation. I would therefore strongly advise against this plan and recommend it does not go ahead'. The trust told us they had carried out an infection control risk assessment however we were provided with no evidence of this. The triumvirate team and site team continued to attempt to pressure ED staff to nurse patients in the corridor despite the risk assessment stating this contravenes fire regulations. The service had not undertaken any risk assessment on the impact of nursing additional corridor patients would have on infection control practices.

Staff were unclear on who was responsible for the health of patients on the back of ambulances waiting outside the department awaiting treatment. Some staff believed ambulance staff were responsible whilst other staff believed they were responsible. Ambulance staff told us they rarely saw staff from within the department to assess patients who were in ambulances. Following the inspection, the trust ensured all staff were aware of the proper procedures with regards to managing patients on the back of ambulances.

There were risks we identified which staff were aware of, however these were not on the departments risk register at the time of inspection. We reviewed the service wide risk register following the inspection and risks such as medicines management issues, which were known amongst the staff, were not included within the ED risk register.

Information Management

Patient information was not always secure. 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. Data or notifications were consistently submitted to external organisations as required.

Staff did not always manage patient confidentiality effectively. Patient notes in majors C were left in trays and were potentially accessible to anyone within the department at the time. There were also times when staff left a mobile desk and computer unattended with patients' names and conditions displayed. At the ED reception area, there was a computer with patient information on facing towards the main window and was visible to people in the waiting room.

The service collected reliable data and analysed it. Leaders within the service had access to national benchmarking data and staff had access to live data about timeliness of patient care.

There were clear performance measures in place, and staff had tried to work towards these targets. During the inspection staff had struggled to meet these targets. However, it was clear staff had put in place improvements in order to attempt to reach them. Such as, the inclusion of an ambulance navigation nurse to improve performance against the 15-minute target for ambulance handovers into ED.

The service had effective arrangements to ensure data or notifications were submitted to external bodies as required. During the inspection process, the trust sent data in a timely manner.

Engagement

Leaders and staff engaged with patients, staff and the public to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders engaged with staff. Managers had put a 'you said we did' suggestions box in the staff room. Leaders used social media to share information and make requests such as shift swaps. The service had a closed messaging group and the senior teams had a separate group to communicate and immediately share information. The service had regular staff meetings. The service had an established wellbeing team who could provide links to support services for staff.

The service had some engagement with patients and the public. Leaders said they were holding patient engagement groups in July 2021 to review and develop the 'perfect patient journey' process.

Leaders collaborated with partner organisations to try and improve the patient experience. The service worked with the local ambulance provider in order to try and speed up the time it took for patients to be admitted into the majors department.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

The service had ongoing quality improvement and service development projects. This included, but is not limited to, the opening of the new Paediatric Emergency Department at Good Hope Hospital; this included ten treatment cubicles, a new ambulance area and drop off.

Some staff within the ED told us they struggled to make time to engage in quality improvement, innovation or research.