This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

University Hospitals Birmingham (UHB) is a Foundation Trust and has approximately 50,000 members, and employs more than 20,000 members of staff. It is one of the largest trusts in England, treating more than 2.2 million patients each year and has more than 2,700 beds across its sites. UHB serves a regional, national and international population.

The trust is a regional centre for cancer, trauma, renal dialysis, burns and plastics, HIV and AIDS, as well as respiratory conditions like cystic fibrosis. The trust also has expertise in bone marrow transplants and thoracic surgery and have the largest solid organ transplantation programme in Europe.

In addition, the trust provides a series of highly specialist cardiac, liver and neurosurgery services to patients from across the UK.

The Queen Elizabeth Hospital Birmingham has been designated both a level one trauma centre and host of the UK’s only £20m National Institute for Health Research (NIHR) Surgical Reconstruction and Microbiology Research Centre (SRMRC).

*(Source: Trust website)*

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.
We included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

**Acute hospital sites at the trust**

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital, Birmingham</td>
<td>Mindelsohn Way, Edgbaston, Birmingham, B15 2WB</td>
<td>All CQC core services other than maternity, gynaecology and services for children and young people</td>
<td>A mixture of local and regional services</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>Bordesley Green East, B9 5SS</td>
<td>All nine CQC acute core services</td>
<td>A mixture of local and regional services</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>Good Hope Hospital, Rectory Road, Sutton Coldfield, B75 7RR</td>
<td>All nine CQC acute core services</td>
<td>Regional</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>Solihull Hospital, Lode Lane, Solihull, B91 2LJ</td>
<td>All CQC acute core services other than gynaecology and services for children and young people</td>
<td>Regional</td>
</tr>
</tbody>
</table>

The trust also provides services at Birmingham chest clinic, Castle Vale renal dialysis centre and Runcorn Road renal dialysis centre.

(Source: Routine Provider Information return (RPIR) - Sites tab)

**Patient Numbers**

**Heart of England NHS Foundation Trust (HEFT) (provided for contextual purposes)**

**Inpatient admissions**

220,499  
(+5% from previous year)

**Outpatient attendances**
1,133,729  
(0% from previous year)

**A&E attendances**

275,003  
(+2% from previous year)

**Number of deliveries (Babies Born)**

9,258  
(-6% from previous year)

*July 2017 to June 2018 Hospital Episode Statistics*

**University Hospital Birmingham NHS Foundation Trust**

**Inpatient admissions**

117,985  
(+4% from previous year)

**Outpatient attendances**

1,082,496  
(+3% from previous year)

**A&E attendances**

118,928  
(+3% from previous year)

*July 2017 to June 2018 Hospital Episode Statistics*

**What people who use the trusts services say**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust scored about the same as the England average for recommending the trust as a place to receive care from September 2017 to August 2018.
Patient-led assessment of the Care Environment (PLACE)

HEFT and University Hospital Birmingham NHS Foundation Trust

In the Patient-led assessment 2018 of the care environment for all indicators, privacy, dignity and well-being, cleanliness of environment, environment for dementia care and assessment of facilities and food the trusts scores remained in line with the England average.

CQC Inpatient Survey

HEFT

Feedback from adult inpatients (aged 16 or over) who spent at least one night in hospital during July 2017.

- Where has patient experience improved from 2016 to 2017? Two areas had improved:
  - Staff discussing further health or social care service needs
  - Told how to make a complaint about care

- Where has patient experience declined from 2016 to 2017? One area had declined
  - Enough nurses on duty to provide care continued to be better?

There were no areas better than expected in both years and there were no areas worse than expected in both years

University Hospital Birmingham NHS Foundation Trust

- Where has patient experience improved from 2016 to 2017? One area had improved
  - Staff answering questions before operation/procedure

- Where has patient experience declined from 2016 to 2017? One area had declined
Staff giving conflicting information

- Where has patient experience continued to be better? One area performed better than expected:
  - Written instructions provided for after leaving hospital

There were no areas worse than expected in both years

**CQC Maternity Survey (HEFT)**

In the CQC Maternity Survey 2017 the trust scored the same as other trust for the indicators raising concerns, staff introductions, advice at the start of labour Information or explanations given after birth and moving during labour. The trust scored the same as other trusts for the two indicators being left alone and treatment with dignity and respect, however these indicators had improved from the previous survey.
**Is this organisation well-led?**

**Leadership**

To write this well-led report, and rate this organisation, we interviewed members of the board, including both executive and non-executive directors. We held focus groups with a range of senior staff across the trust, this included a wide group of clinical and non-clinical service and specialty directors. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans; board meeting minutes and papers to the board, investigations, and feedback from patients, local people and stakeholders.

**Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.**

We carried out checks to determine whether appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. A fit and proper persons (FPPR) procedure was in place.

Fit and Proper Person checks were in place. We reviewed the personal files of four executive directors and two non-executive directors to determine the necessary fit and proper person checks had been undertaken. Our checks included the chief executive (CEO), interim medical director and executive chief nurse, all of whom had been in post for less than three months at the time of this inspection. Board members completed annual self-declaration forms to confirm that they complied with the regulation. All files had an annual declaration within them in line with FPPR. We found all files were fully compliant with FPPR.

**There was clear leadership of the trust to drive and improve the delivery of high quality person centred care.**

The board of directors managed the trust's services and developed plans and strategies for the future. The board included full-time executives and part-time non-executive directors. Non-executive directors are not full-time employees of the trust. They help to ensure the trust is accountable to the people it serves. They are people who live or work in the area and have shown an interest in the provision of health services for the local people.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The board of directors included a chair, chief executive, two chief operating officers, executive chief nurse, chief financial officer, eight directors and nine non-executive directors. The board of directors was accountable to the board of governors for the running and performance of the trust and was supported by the audit committee and the executive appointment and remuneration committee. The trust board appeared stable, but there had been a change in the chief executive (CEO), medical director (MD) and executive chief nurse in the two months preceding this inspection. However, both the CEO and MD had previously held alternative executive roles within the organisation.

The CEO took up the role of deputy chief executive with responsibility for clinical quality at Heart of England NHS Foundation Trust (HEFT) in November 2015, in addition to the medical director role at University Hospitals Birmingham (UHB), and was appointed as executive medical director of
HEFT in March 2016. When the acquisition took place in April 2018, the CEO continued in their role as executive medical director and also became the deputy chief executive for the combined trust. The CEO was appointed on 1 September 2018.

The executive lead for Autism and Learning Disability services was the executive chief nurse, whilst the director of corporate affairs was the executive lead for mental health services.

The trust had 23 governors on its council. The council of governors helped to shape the strategic direction of the trust. Their role was to hold the non-executive directors individually and collectively to account for the performance of the board on behalf of all trust members and the public. The governors oversaw the performance of the trust, appointed the chairman and non-executive directors and acted as a link between the trust and its members and the wider community. Elections for the patient, public and staff governors took place on a rolling three-year period.

We met with eight of the governors; they told us, they met with the board of executives and non-executives six times a year and described an “open” relationship with the board. Most of the governors told us they played an active part in holding the board to account. For example, where patient concerns had been raised, governance and recruitment of the CEO and executive chief nurse. However, some of the governors felt they needed more information from the board.

The trust board and senior leadership team displayed integrity on an ongoing basis. Throughout the well led inspection we saw evidence of collective leadership from the trust board with a strong focus on delivering patient-centred care. Collective leadership represents a new way of sharing power, ensuring that leadership and expertise are correlated at every level in relation to every task. It creates a culture in which high quality, compassionate care can be delivered. We found the board wasn’t reliant on any one individual to function effectively. Without exception, we found a cohesive unitary board that had a shared understanding of issues, challenges and priorities in the trust and beyond. The trust board played a pivotal part in the Birmingham and Solihull sustainability and transformation partnership (STP) in order to contribute to improving the health and wellbeing of people living in Solihull and Birmingham.

The trust leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. We observed trust board meetings prior and during this inspection. Meetings were well attended and where the meeting was joint with the council of governors we saw there were numerous hospital governors present. There was appropriate challenge at the board. There were healthy discussions and challenge from the chair and both executives and non-executive directors. The challenge between board members was open and honest. Performance reports were discussed and broken down by site location with individuals well cited on issues and very passionate about their roles.

Throughout our core service and well led inspections and staff focus groups, most staff we spoke with told us members of the board were visible and approachable and although new to the organisation, the executive chief nurse was spoken of positively by staff.

The trust had an operational structure which comprised of nine divisions; five across the Heartlands, Good Hope and Solihull (HGS) sites and four at the Queen Elizabeth site. Triumvirate leadership was provided at divisional level by a divisional director, director of operations and head of nursing. Each individual was supported by a deputy. Local leadership was provided by ward/department managers and matrons. The divisional teams were each supported by a divisional finance manager.
Leadership of pharmacy services was provided by a chief pharmacist.

Clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership were in place, with a leadership development and training programme in the process of being formalised by the trust.

Leadership development opportunities were available, including opportunities for staff below team manager level. The executive team were clearly sighted on the development needs of senior staff within the organisation and recognised the size of the new organisation demanded changes to how support and development for senior staff was delivered. A staff group of approximately 20,000 staff meant that expectations around direct support from the CEO for senior staff was not practical. The CEO was keen to build resilience throughout the executive team, with deputies taking on a much more senior role to ensure support was readily available to those working at a lower level.

Prior to the acquisition, both organisations offered a range of leadership development interventions, and promoted access to in-house, regional and national leadership programmes and courses. Both organisations had a membership with NHS elect, and staff benefitted from participating in a range of masterclasses to strengthen leadership capabilities.

Following the acquisition, the trust had established a leadership development group, to understand the previous leadership development activity across both organisations and to determine priorities for the new trust. The trust had recently accessed the Health Education England ‘Talent Management Practitioner Programme’ and was discussing formalising board level succession plans and options for introducing a talent management framework across the trust. This initial work was to help to inform a longer-term leadership and talent management strategy. Through trust staff networks, national and local leadership programmes were promoted.

In May 2018, the trust invited 89 senior leaders to complete a survey explaining the development they had received in the last three years. Following this survey, the trust had agreed five priorities for leadership development during 2018/19:

- Increase participation in external academic programmes.
- Deliver a senior leadership development course to reflect the trust’s new vision and values and the behaviours needed to create a positive culture.
- Commence a series of monthly leadership lectures across a range of leadership topics.
- Implement mentoring and coaching programmes.
- Create shadowing opportunities for staff to gain exposure to senior leadership activities.

**Board Members**

Of the executive board members at the trust, 0.0% were Black and Minority Ethnic (BME) and 42.0% were female.

Of the non-executive board members 20.0% were BME and 60.0% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>42.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>20.0%</td>
<td>60.0%</td>
</tr>
</tbody>
</table>
All board members | 11.8% | 52.9%

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

Of the executive board members at the trust, 0.0% were Black and Minority Ethnic (BME), this was not reflective of the local population, however, the board were aware of this and told us, due to a very stable management structure at senior level there were few opportunities becoming available for new or existing staff progressing to higher grades. However, the trust had started to take action to help develop a more diverse senior team. Actions already taken included for example:

- A BAME staff network
- Unconscious bias training
- Formalised access to ‘acting up’
- Including positive action statements on band 8 and 9 job adverts

Future actions planned included for example:

- Introducing unconscious bias training to leadership programmes
- Working with local BAME community groups to raise the profile of the trust as a diverse employer
- Introduce ‘reverse mentoring’

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The vision aligned with the aspirations of the Birmingham and Solihull sustainability and transformation partnership (STP) to strengthen partnership working and to develop integrated pathways between in-hospital services, out-of-hospital services and social care that would improve outcomes for all the populations that were served.

The trust had a clear vision and a set of values, with quality and sustainability as their top priorities. The trust vision; “to build healthier lives” was underpinned by five organisational values:

- Collaborative: working in partnership with others to provide safe, appropriate care and improve outcomes.
- Honest: being transparent in all that we do, communicating openly, inclusively and with integrity.
- Accountable: taking personal and collective responsibility for the way in which we deliver care.
- Innovative: being responsive, creative and flexible, always looking for ways to do things better.
- Respectful: treating everyone with compassion, dignity and professionalism.

The vision ‘to build healthier lives’ was the recently agreed vision of the Heart of England NHS Foundation Trust (HEFT). Senior managers told us, adoption of this vision would reinforce the message that, although technically an acquisition, it was a merger by nature which would take best practice and learning from both trusts.

Staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team. The board, senior leaders and frontline staff across the organisation lived the vision and demonstrated the trust values.
Across the trust the vision and values were well known. They were a key focus of the trust's corporate induction programme and managers were clear how their teams delivered them. For individual staff the trust's values were a key element of appraisal including demonstrating how they had incorporated the values in their work over the last year.

There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care. The trust aligned its strategy to local plans in the wider health and social care economy. This included active involvement in sustainability and transformation plans and reflected the direction of the new organisation and wider health system reforms.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The new version of the strategy was the product of wide engagement with board members and governors, with clinical and corporate leaders, with staff across the sites of the organisation, and with stakeholders, including patient representatives and system partners in the STP. As part of the updated strategy the trust was aspiring to manage three major challenges in parallel:

- Continuous quality and productivity improvement – ‘excellence within each hospital’
- Embedding the acquisition and realising benefits – ‘excellence as a group of hospitals’
- Leading system reform through the STP – ‘excellence as a health system’

Underpinning the trust strategy were eight strategic aims:

- Always put the needs and care of patients first
- Advance our reputation and position at the leading edge of performance and quality
- Enhance our reputation for excellent financial management and efficiency
- Provide first class facilities by delivering the New Hospitals Project
- Be an employer of choice
- Educate and train the healthcare workforce of the future
- Research and develop the healthcare services of the future
- Become a community asset for Birmingham and beyond

The strategy and plans in place were fully aligned with plans in the wider health economy including, recognising the mental and physical health of the local population, and there was a commitment by all board members to system-wide collaboration and leadership.

To support the delivery of the trust’s new strategy a new approach to operational planning was being developed to be adopted from 2019/20. This was to build upon the existing approaches used at the trust whilst recognising that the trust was in a period of fundamental transition to become a far larger, multi-site trust. Board meeting minutes we reviewed showed, an update on the process was provided to the board of directors in October 2018. The detail of the plan was to be developed over the subsequent three months and was to be presented to the board of directors for final approval in April 2019.

The trust’s vision, key areas of strategic focus and values were communicated to all staff in the communications around the acquisition and, a programme of communications and engagement was to be in place when the new strategy was launched to ensure all staff were aware of and committed to the new strategy. Directors and senior leaders, we spoke with, were well cited on this new strategic phase for the organisation.

During our interview with the chief pharmacist we were told, there was no current pharmacy strategy as there was a desire to establish the needs of the evolving organisation before
establishing a plan. However, the chief pharmacist described current priorities including improving communication, establishing an effective senior management team with support at each site, aligning processes, development of the antimicrobial pharmacist role and roll out of the administration technician roles as well as training and support for more independent pharmacist prescribers. We saw/heard these priorities being addressed during the core inspection and during our focus group conversation with staff.

A key priority for the pharmacy team was the alignment of policies across all sites and the development of staff within the team to deliver a consistent service in each hospital. There was an intention to ensure good practice at each site was identified and then shared to ensure this was not lost. In order to identify current practices and establish the priorities on each site for medicines optimisation the chief pharmacist was holding monthly meetings with staff. We heard positive comments about this from staff but lower grades on one site felt excluded from the process.

We were told, and saw evidence from meeting minutes, that the hospital management teams were involved and aware of the developments and achievements of the pharmacy service.

Culture

The executive board were committed to promoting a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The board demonstrated to us a shared purpose, where they {the board} were striving to deliver and motivate staff to succeed. All members of the board consistently told us they were proud of their workforce especially given the challenges staff had faced with the recent acquisition and with challenges around capacity and flow and staffing.

We met with different grades of staff during our core service inspection, through staff focus groups and during this inspection. We also received staff feedback through our National Customer Service Centre. Most staff we spoke with valued the executive team and were especially complimentary of the executive chief nurse.

The trust’s strategy, vision and values underpinned a culture which was patient centred. Generally, staff felt supported, respected and valued and without exception, staff articulated a desire to “do the best” for their patients. However, there were small pockets of staff where morale appeared low, largely due to challenges with medical and nurse staffing and a perceived culture of intimidation and bullying.

The Staff Friends and Family Test (FFT) is a feedback tool which enables NHS staff to give regular feedback about their organisation as a place to work and to receive care or treatment. The quarter two staff FFT ran from 27 August 2018 to 21 September 2018 and a third of staff from all sites were randomly selected to take part. The trust response rate was 21.5%. The survey consisted of the two mandatory recommender questions and the trust’s culture metric. Recommender scores for the trust were:

- Recommend for care and treatment 82%
- Recommend as a place to work 62%

The Heartlands, Good Hope and Solihull (HGS) sites saw their highest score for ‘recommend for care and treatment’, since the survey began and scores remained consistent for ‘recommend as a place to work’. The Queen Elizabeth (QE) site saw a 5% decline for ‘recommend as a place to
work’. The culture metric scores showed that an awareness of the trust values had increased across all sites.

During our interviews with members of the executive and non-executive team, we found leaders were cited on areas where morale was low and had already taken or, were in the process of acting to address concerns. In addition, executive leads told us there was a strong emphasis on the safety and wellbeing of staff at this organisation. In the year ahead, the trust was to be focusing on four key corporate priorities:

- **Staff Wellbeing**: We will be providing additional resilience workshops for staff and training managers on mental health issues, so they can better support staff experiencing stress and other mental health concerns.

- **Staff recognition**: In order to address the decrease in staff motivation at work, we are developing a staff retention strategy, which will include finding more regular ways to recognise and reward our staff and looking at ways to make it easier for staff to move into new roles across the Trust.

- **Leadership**: We are committed to developing our leaders, and are running a series of leadership focus groups, to identify priorities for the year, which will help to inform the draft leadership strategy for the new Trust.

- **Flexible working / work-life balance**: Exploring new approaches to flexible working, to support staff wellbeing and staff retention. Current actions include a homeworking pilot for corporate staff and a trial of 100% self-rostering, to give staff more say on their working patterns.

Actions taken to date included for example; the implementation of a ‘health and wellbeing’ practitioner to support staff with mental health, health and well-being and nutrition; signposting to additional support for example, a menopause clinic; access to clothing and food banks and, secured loans.

Most staff told us they felt able to raise concerns and were aware of trust policies and processes in place enabling them to do so.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. Freedom to speak-up guardians (FTSUG) were introduced following Sir Robert Francis’s Freedom to Speak-up Review (2015). Their role is to work with leadership teams to create a culture where people can speak-up to protect patient safety. Following the acquisition, it was identified at board level that the trust would need to align its approach to speaking up/raising concerns, and within that portfolio review the FTSUG role within the enlarged organisation. This coincided with the two guardians for the two pre-merged trusts relinquishing the roles. It was felt by the board that this would be a useful opportunity to appoint a sole guardian across all the sites and re-launch the role of both the guardian and confidential contacts across all sites.

A new FTSUG was appointed in July 2018. In addition, a cohort of confidential contacts across the sites had been increased to 22, some with special interest in the BAME (black, Asian and minority ethnic), LGBT (lesbian, gay, bisexual and transgender) and disability agenda. Training was provided for these roles by the Regional Network of the National Guardian’s Office and various internal resources had been refreshed including an intranet page, dedicated inbox, screensavers and a wider FTSUG campaign to raise awareness.
The board had a dedicated executive and non-executive lead for FTSUG. Both met regularly with the FTSUG alongside the chief executive and chair. The number of contacts to the FTSUG or confidential contacts team were monitored for themes and a report submitted to the board quarterly. For the reporting period April 2018 to September 2018 there were 14 cases brought to the FTSUG or a confidential contact. One was anonymous and raised concerns around patient safety and alleged bullying and harassment. Three related to patient safety concerns and ten related to human resource issues. We reviewed records of all concerns raised and noted all concerns had been acted upon and resolved appropriately.

The trust had appointed a Guardian of Safe Working Hours (GSWH). The Guardian of Safe Working Hours has been introduced to protect patients and doctors by making sure doctors are not working unsafe hours. Guardians act as the champion of safe working hours for doctors in approved training programs. They record and monitor compliance with the restrictions on working hours and provider assurance to the trust board that doctors are safely rostered. Exception reporting was to the board quarterly.

During our inspection we met with the GSWH. In addition, a deputy GSWH was also in post to ensure all sites were covered appropriately. The GSWH targeted junior doctors through the junior doctor forum, through education forums, at induction and through an outreach system whereby GSWH would regularly visit areas where there were issues with staffing or a surge in capacity.

The culture of the organisation encouraged openness and honesty at all levels, including with people who used services, in response to incidents. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and appropriate learning and action was taken as a result of concerns raised. The trust was a regular reporter to the National Reporting Learning System (NRLS). At the HGS sites the trust was in the middle 50% of reporters when compared nationally and the median time taken to report incidents was 19 days compared to 30 for all trusts between October 2017 and March 2018. At the QE site the trust was in the highest 25% of reporters when compared nationally and the median time taken to report incidents was six days compared to 30 for all trusts between October 2017 and March 2018.

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

The trust applied duty of candour appropriately. The head of clinical governance and patient safety was the lead responsible for duty of candour in the trust. As outlined in the policy for the reporting and management of incidents including serious incidents the trust managed all incidents of moderate, severe harm or death in accordance with the trust ‘being open’ policy and procedure which detailed how staff should adhere to the duty of candour requirements. Both these policies were currently under review following the acquisition in April 2018.

Compliance with duty of candour requirements in line with trust policy was monitored by the governance facilitation teams. For every patient safety incident reported as moderate, severe or catastrophic, the governance facilitation teams would liaise with the relevant specialties or teams responsible for the patient’s care to ensure that the duty of candour was completed in a timely manner and evidence was recorded. Compliance with the duty of candour requirements was reported to the commissioners (CCG) monthly. The CCG had also reviewed the trust’s process for
ensuring compliance with the regulations and were satisfied that the duty of candour requirements was being met.

The tables below detail compliance with initial duty of candour (DoC) for qualifying incidents for the reporting period April 2018 to October 2018.

| QE | Number of incidents meeting DoC threshold | 85 |
| Number of these incidents with initial DoC completed within 10 days | 83 (97.6%) |
| Number not yet complete, but meeting to discuss with patient and/or next of kin (NOK) arranged | 2 (2.4%) |
| Total compliance | 100% |

| Number of incidents meeting DoC threshold | 266 |
| Number of these incidents with initial DoC completed within 10 days | 266 |
| Total compliance | 100% |

The tables below detail compliance with the second stage of DoC for the reporting period April 2018 to October 2018.

| QE | Number of incidents where patient and/or NOK indicated they would like feedback from investigation | 46 |
| Number with feedback provided | 44 (95.6%) |
| Number with feedback not yet provided but investigation ongoing | 2 (4.4%) |
| Total compliance as of 01 November 2018 | 95.6% |

| Number of incidents where patient and/or NOK indicated they would like feedback from investigation | 257 |
| Number with feedback provided | 187 (72.7%) |
| Number with feedback not yet provided but investigation ongoing | 70 (27.3%) |
| Total compliance as of 01 November 2018 | 72.7% |

The number of incidents for HGS was lower in the second table primarily due to cases where the patient and/or NOK indicated as part of the initial disclosure of the incident that they did not wish to receive further feedback or information. In other cases, initial concerns were addressed in the initial DoC letter and no further investigation had been required. There were also instances where the patient had passed away (unrelated to the incident) and had no NOK.

Most staff across the organisation were familiar with the requirements of the duty of candour regulation and talked about the importance of being open and transparent with patients and the public. Awareness of being open and the duty of candour requirements was provided to staff at a number of training sessions. Compliance with training was reported to divisions and specialties to increase awareness of the duty or candour requirements. Information was also available on the trust’s intranet.

All staff had the opportunity to discuss their learning and career development needs at appraisal. Mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations were in place. As of November 2018, the total percentage number of staff that had received an appraisal in the last 12 months was 85.4%. This was in line with the trust target of 85%.
Following the acquisition, improving the culture in the pharmacy team across all sites had been identified as a priority. The chief pharmacist was seeking to gather the team views through regular face to face meetings, the ability to ask anonymous questions and was developing a survey monkey to further gain an understanding of the concerns in each area.

We were told that compliments and concerns about services were shared in team meetings to ensure all staff were informed but we heard from staff that this did not happen universally at all sites or in all appropriate staff meetings.

Most of the pharmacy team staff we spoke to were positive about working for this trust.

**Staff Diversity**

As of 31 December 2017, University Hospitals Birmingham employed 9,417 people, of which:

- 71.9% are women
- 10.6% are aged 25 years and under and 5.4% are aged 61 years and over.
- Across the trust 36.1% of staff are from Black Minority and Ethnic Communities.
- 1.9% of staff have disclosed that they consider themselves to have a disability, 71.2% of staff have told us they don’t consider themselves to have a disability with the remainder either unknown or have chosen not to disclose
- 65.7% of staff have disclosed as Heterosexual and 1.9% as Lesbian, Gay or Bisexual with the remainder unknown or chose not to disclose.
- 39.3% of staff considers themselves Christian, 7.8% as Atheists and 5.9% of staff disclosing their religion to be Islam.
- 35.5% chose not to disclose their religion or belief

(Source: Annual Equality Report 2017)

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group as at 31 March 2018.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>University Hospitals Birmingham NHS Foundation Trust</th>
<th>Heart of England NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical and dental staff (%)</td>
<td>Nursing and midwifery staff (%)</td>
</tr>
<tr>
<td>White</td>
<td>49.7%</td>
<td>67.8%</td>
</tr>
<tr>
<td>Mixed</td>
<td>2.4%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>35.1%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>2.4%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Chinese</td>
<td>2.9%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>4.4%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>3.3%</td>
<td>1.8%</td>
</tr>
</tbody>
</table>
Executive leaders told us equality and diversity was promoted within and beyond the organisation and through its commitment to delivering equal opportunities for all staff and service users had developed the following objectives:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well supported staff
- Inclusive leadership at all levels.

The trust employed a team of chaplains from a variety of faith traditions to meet the spiritual, religious and pastoral needs of patients, relatives and staff. This support was not limited to those who were religious.

Policies and procedures were in place to meet the needs of staff and the local community and any ethnicities represented within it.

However, not all staff, with particular protected characteristics under the Equality Act, for example, BAME did not feel they were treated equitably. We spoke with 15 BAME staff as part of our staff focus groups. Most staff gave us negative examples of their experience of working for this organisation. Themes included; the diversity of the executive board did not reflect the diversity of staff across the organisation; negative values and behaviours of non-BAME staff and, lack of career progression. Executive leaders were cited on concerns raised and told us actions had been put in place following the publication of their Workforce Race Equality Standard (WRES) report in July 2018 (see below in this report).

**NHS Staff Survey 2017- results better than average of acute trusts**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust has 19 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appraisals &amp; support for development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>88</td>
<td>86</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.07</td>
<td>4.05</td>
</tr>
<tr>
<td><strong>Errors &amp; incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>27</td>
<td>31</td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>91</td>
<td>90</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.71</td>
<td>3.65</td>
</tr>
<tr>
<td>Working patterns</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>52</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job satisfaction</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.98</td>
<td>3.75</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>72</td>
<td>70</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.95</td>
<td>3.91</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.74</td>
<td>3.72</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.44</td>
<td>3.31</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managers</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.48</td>
<td>3.45</td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.77</td>
<td>3.74</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient care &amp; experience</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>4.02</td>
<td>3.91</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>90</td>
<td>90</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Violence, harassment &amp; bullying</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>*KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>26</td>
<td>28</td>
</tr>
<tr>
<td>*KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>46</td>
<td>45</td>
</tr>
</tbody>
</table>

*indicates a key finding where lower scores are better.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust has five key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Appraisals &amp; support for development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>90</td>
<td>86</td>
</tr>
<tr>
<td><strong>Errors and incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>27</td>
<td>31</td>
</tr>
<tr>
<td><strong>Working patterns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF16. % working extra hours</td>
<td>70</td>
<td>72</td>
</tr>
<tr>
<td><strong>Violence, harassment &amp; bullying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>46</td>
<td>45</td>
</tr>
</tbody>
</table>

*indicates a key finding where lower scores are better.

**NHS Staff Survey 2017 – results worse than average of acute trusts**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust has four key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality &amp; diversity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* KF20. % experiencing discrimination at work in the last 12 months</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td><strong>Health and wellbeing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>53</td>
<td>52</td>
</tr>
<tr>
<td><strong>Working patterns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF16. % working extra hours</td>
<td>73</td>
<td>71</td>
</tr>
<tr>
<td><strong>Violence, harassment &amp; bullying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

*indicates a key finding where lower scores are better.

**Heart of England NHS Foundation Trust**
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust has 22 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality and diversity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>KF20. % experiencing discrimination at work in last 12 months</em></td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>79</td>
<td>85</td>
</tr>
<tr>
<td><strong>Errors &amp; incidents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>89</td>
<td>90</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.62</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.59</td>
<td>3.65</td>
</tr>
<tr>
<td><strong>Health and wellbeing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>KF17. % feeling unwell due to work related stress in last 12 months</em></td>
<td>39</td>
<td>36</td>
</tr>
<tr>
<td><em>KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</em></td>
<td>55</td>
<td>52</td>
</tr>
<tr>
<td>KF19. Org and management interest in and action on health and wellbeing</td>
<td>3.47</td>
<td>3.62</td>
</tr>
<tr>
<td><strong>Working patterns</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>46</td>
<td>51</td>
</tr>
<tr>
<td><strong>Job satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.56</td>
<td>3.75</td>
</tr>
<tr>
<td>KF4. Staff motivation at work</td>
<td>3.87</td>
<td>3.92</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>67</td>
<td>70</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.86</td>
<td>3.91</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.65</td>
<td>3.72</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.27</td>
<td>3.31</td>
</tr>
<tr>
<td><strong>Managers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF5. Recognition and value of staff by managers and the organisation</td>
<td>3.36</td>
<td>3.45</td>
</tr>
<tr>
<td></td>
<td>Score 1</td>
<td>Score 2</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>30</td>
<td>33</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.69</td>
<td>3.74</td>
</tr>
<tr>
<td><strong>Patient care &amp; experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.56</td>
<td>3.71</td>
</tr>
<tr>
<td><strong>Violence, harassment &amp; bullying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>65</td>
<td>66</td>
</tr>
</tbody>
</table>

*indicates a key finding where lower scores are better.

(Source: NHS Staff Survey 2017)

**Workforce race equality standard**

The Workforce Race Equality Standard (WRES) is designed to help organisations gauge their current state of race equality and track what progress is being made to identify and promote talented black, Asian and minority ethnic (BAME) staff, as well as helping to eliminate wider aspects of discrimination in the treatment of BAME staff.

The WRES takes a small number of indicators and requires NHS organisations to close the gap between the BAME and white staff experience for those indicators.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.
Of the four questions above, the following three questions showed a statistically significant difference in score between white and BME staff:

- KF26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months.
- KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.
- Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 24%</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>BME 21%</td>
<td>28%</td>
<td>22%</td>
</tr>
<tr>
<td>KF26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 22%</td>
<td>25%</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>BME 26%</td>
<td>27%</td>
<td>28%</td>
</tr>
<tr>
<td>KF21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 88%</td>
<td>87%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>BME 74%</td>
<td>75%</td>
<td>76%</td>
</tr>
<tr>
<td>Q17b</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the 12 last months have you personally experienced discrimination at work from a manager / team leader or other colleagues?</td>
<td>White 7%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>BME 13%</td>
<td>15%</td>
<td>14%</td>
</tr>
</tbody>
</table>
Of the four questions above, the following two questions showed a statistically significant difference in score between white and BME staff:

- KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.
- Q17b. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

In line with the NHS England mandate, the trust’s WRES report for July 2018 was published on their website. As a result, several actions had already been taken by the trust and included for example:

- The acquisition providing the trust with a broader opportunity for staff mobility and increasing the specialities in which staff could work.
- Establishing a BAME Staff Network.
- Unconscious bias training was included in the consultant’s four-week induction programme and as part of the trust’s recruitment and selection and human resources (HR) masterclasses, including disciplinary and grievance training.
- The trust had incorporated an inclusion DVD for all new starters joining the trust as part of the corporate induction.
- The trust included positive action statements on Band 8 and 9 job adverts.
- The trust has profiled the career progression of BAME staff from across the bands, including those from middle and senior management, as part of a role model campaign.

During our interviews with individual members of the executive team we were told of additional actions that were due to take place during 2019. These included for example:

- Exploring options to introduce leadership programmes, which will include unconscious bias, to all managers in the trust to reduce bias and discriminatory behaviours.
- Working with local BAME community groups to raise the profile of the trust as a diverse employer.
• Working alongside the local community to support local and sustainable recruitment. This was to involve working alongside local schools to raise the profile of the trust as an employer and advise on career opportunities.

• Developing training programmes for managers with a particular emphasis on the protected characteristics, focussing on how workplace issues impact on personal performance and workplace wellbeing.

**Workforce Disability Equality Standard (WDES)**

From 2018 the trust was to be reporting on the new Workforce Disability Equality Standard. The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant organisations to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality.

The trust was reviewing their compliance with this standard and had a patient and public event planned during our inspection.

**Sickness absence rates**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust’s sickness absence level from June 2017 to May 2018 was similar to the England average.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no
more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust’s sickness absence level from June 2017 to Jan 2018 was higher than the England average.

(Source: NHS Digital)

**General Medical Council – National Training Scheme Survey**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2018 General Medical Council Survey the trust performed the same as expected all 18 indicators in the survey.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2018 General Medical Council Survey the trust performed the same as expected all 18 indicators in the survey.

(Source: General Medical Council National Training Scheme Survey)

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
The trust provided their Board Assurance Framework, which details a number of strategic risks.

A summary of these is below. All these risks were rated between four and 20. Risk ratings are calculated by multiplying the likelihood risk score by the consequence risk score.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SR1/18</td>
<td>Financial deficit significantly in excess of planned levels</td>
<td>9 (3x3)</td>
<td>6 (2x3)</td>
</tr>
<tr>
<td>SR2/18</td>
<td>Cash flow affects day to day operations of Trust</td>
<td>12 (4x3)</td>
<td>6 (2x3)</td>
</tr>
<tr>
<td>SR3/18</td>
<td>Failure to meet operational performance targets</td>
<td>20 (5x4)</td>
<td>9 (3x3)</td>
</tr>
<tr>
<td>SR4/18</td>
<td>Increasing delays in the transfer of care from UHB sites in excess of agreed targets.</td>
<td>20 (5x4)</td>
<td>9 (3x3)</td>
</tr>
<tr>
<td>SR5/18</td>
<td>Unable to meet requirements of staffing model</td>
<td>16 (4x4)</td>
<td>12 (3x4)</td>
</tr>
<tr>
<td>SR6/18</td>
<td>Regulatory action</td>
<td>12 (3x4)</td>
<td>4 (1x4)</td>
</tr>
<tr>
<td>SR7/18</td>
<td>Failure of IT systems to support clinical services and business</td>
<td>6 (3x2)</td>
<td>4 (2x2)</td>
</tr>
<tr>
<td>SR8/18</td>
<td>Adverse impact of BREXIT on Trust innovation agenda</td>
<td>12 (4x3)</td>
<td>8 (4x2)</td>
</tr>
<tr>
<td>SR9/18</td>
<td>In-patient infections significantly in excess of agreed national levels</td>
<td>4 (2x2)</td>
<td>4 (2x2)</td>
</tr>
<tr>
<td>SR10/18</td>
<td>Failure of commercial ventures</td>
<td>6 (2x3)</td>
<td>6 (2x3)</td>
</tr>
<tr>
<td>SR11/18</td>
<td>Merger has adverse effect on new trust</td>
<td>9 (3x3)</td>
<td>6 (2x3)</td>
</tr>
<tr>
<td>SR12/18</td>
<td>Unable to maintain and improve the quality and quantity of physical environment to support required level of service</td>
<td>16 (4x4)</td>
<td>9 (3x3)</td>
</tr>
</tbody>
</table>


The board assurance framework (BAF) provided an effective structure, process and system of accountability to support the delivery of the strategy and good quality, sustainable services and was aligned to the strategic aims of the organisation.
Following the acquisition in April 2018, the director of corporate affairs met with executive directors to consider and agree the strategic risks for the enlarged trust. This included a review of historical risks from the Queen Elizabeth (QE) and Heartlands, Good Hope and Solihull (HGS) BAFs to confirm whether they still applied to the trust. The controls for each of the strategic risks and the assurance provided had also been agreed with executive directors and reflected in the updated BAF.

There was a process for the BAF to be reviewed. The strategic risk register and the BAF were reviewed by executive directors each quarter to ensure that they reflected the current risks and the sum of assurance for the trust.

Our review of the strategic risks and BAF found them to be presented in a clear and logical format starting with a high-level summary followed by a more detailed analysis of each risk description. Each BAF risk had a named executive lead who held responsibility for the risk.

In addition, we reviewed the board of directors’ risk appetite statement. This made clear the board of directors’ expectations in relation to the category of risks they expected management teams to identify and the level of such risk that was acceptable.

The risk appetite statement was based on the premise that the lower the risk appetite, the less the board was willing to accept in terms of risk and consequently the higher levels of controls that must be put in place to manage the risk. The higher the appetite for risk, the more the board was willing to accept in terms of risk.

Risks at an operational level were considered under the following categories; quality, regulation and compliance, reputation, people and resource, information and communication technology, finance and efficiency and health and safety. Some category of risks had various sub-categories. For example, quality risks had sub-categories relating to safety, effectiveness and patient experience.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures.

Governance structures, processes and systems of accountability were set out, understood and effective. The trust corporate governance policy (dated 29 March 2018) appropriately outlined the trust’s corporate governance framework and stated the principles of good governance that underpinned the trust’s operations. This ensured all levels of governance and management functioned effectively and interacted with each other appropriately.

Governance within a division, service or specialty was supported by governance facilitation teams from within the risk and compliance teams. The implementation and operation of governance locally, remained the responsibility of the relevant management team.

Papers for board meetings and other committees were of a good standard and contained appropriate information. We reviewed a number of papers as part of our inspection including for example, minutes from board meetings, the audit committee, contract review meetings and the quality committee. Minutes were found to be clear and well presented with clear actions identified.

The council of governors and non-executive (NED) and executive directors were clear about their areas of responsibility. The council of governors held the NEDs individually and collectively to
account for the performance of the board of directors and represented the interests of the members of the trust.

The board of directors was responsible collectively for the success of the trust and the achievement of its objectives. Accordingly, all members of the board had joint responsibility for the operational and financial management of the trust on a day-to-day basis, regardless of their individual skills or status. An appointed senior independent NED provided a conduit between the governors and the board.

NEDs chaired a range of board sub committees which reported directly through to the board. These included:

- The audit committee.
- The clinical quality committee.
- The executive appointments and remuneration committee.
- The investment committee.

The committees’ defined terms of reference were published on the trust’s website. Reports of their activities were given regularly to the board of directors.

A revised board of directors’ unannounced governance visit programme was launched in June 2018. Up to five visits took place simultaneously on the morning of the board of directors' or clinical quality committee meetings each month. Locations for the visits were selected by the executive medical director’s team and the head of clinic governance and patient safety. Wards or departments were selected using a variety of data sources. For example, incidents including near misses, complaints, clinical indicator/clinical dashboard performance information and operational changes. Visit teams comprised a combination of non-executive and executive directors plus other directors, supported by members of the executive medical director's team.

Following each visit, a feedback report was compiled by the executive medical director’s team. Areas of good practice were noted as well as areas for improvement. The report was agreed by each visit team and then shared with the relevant divisional management team to follow up. Feedback reports and actions were reported to the trust’s Clinical Quality Monitoring Groups (CQMGs). Feedback reports were appended to the executive medical director’s patient safety exception report to the clinical quality committee. A summary of the feedback reports was also reported as part of the published board of directors’ clinical quality report. The executive medical director’s team were responsible for monitoring the implementation of actions identified through the visit programme.

The medicines team fed into the trust governance structures at a number of different points, primarily through the locality (site based) clinical quality management groups (CQMG) and through the cross-trust medicines management action group. The Controlled Drugs Accountable Officer role held by the chief pharmacist who reported directly to the trust wide CQMG and from there straight to the board.

We looked at the process for ensuring patient group directions (PGDs) were appropriately produced, reviewed and signed off within the trust. The process for managing PGDs had been changed to ensure review periods were within legislative limits and the process was not unnecessarily time-consuming or complicated to administer. This was a work in progress as each PGD came up for review but we were told this was to be completed within nine months across each site.
Nursing and other staff education on medicines and medicines administration was a current priority for the pharmacy team. There was good practice within the Heartlands, Good Hope and Solihull sites (HGS) where the pharmacy team were involved in the delivery of medicines administration training but little involvement of the pharmacy team at the Queen Elizabeth (QE) site. The pharmacy team planned to adopt the HGS model for medicines education in the longer term.

A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements. Through our interviews with various board members and reviews of patient records across the core services, it was apparent that the population served by the trust included a significant number of patients requiring mental health support. As such, the trust’s strategy had been developed considering the mental health as well as physical health needs of the population it served.

Strong links, through a service level agreement, were in place with a local NHS mental health trust. Provision included a rapid, assessment, interface and discharge team (RAID) based in the emergency departments (ED) and access to a place of safety suite (POS).

At the time of our core service inspection, a plan was underway to have a dedicated mental health assessment room within the ED that would be used for any mental health assessment. Plans were subject to building works within the ED and the expected completion date was the end of November 2018. This would enable the RAID service to be accredited with PLAN (Psychiatry Liaison Accreditation Network).

Additionally, earlier this year, the trust had launched a new service, aimed at supporting staff caring for patients with mental health needs. The mental health liaison team, which was based on the Clinical Decisions Unit (CDU) at QE, was created due to a perceived gap in mental health services to support the needs of patients and staff in improving the delivery of holistic care. In 2017, senior management recognised the need to employ an experienced mental health nurse to support patients admitted to the unit with acute mental health problems.

The primary role of the team was to teach, train and support staff and improve their confidence as well as challenging mental health stigma and giving advice on the Mental Health Act. The service aimed to improve the quality of holistic care and patient experience and aimed to move towards achieving recommendation from the National Confidentiality Enquiry into Patient Outcome and Death (NCEPOD) guidelines for mental health.

Governance arrangements for safeguarding, at all levels of the organisation, were in place. The executive chief nurse was executive safeguarding lead for the trust. The trust safeguarding group was chaired by the lead nurse for safeguarding adults and children and met on a bi-monthly cycle. The group included representatives from the clinical commissioning group (CCG), the safeguarding team and the divisions within the trust. Safeguarding cases were discussed to share good practice and areas within safeguarding that needed to be improved.

A safeguarding report was presented six monthly at the care quality group which was chaired by the executive chief nurse. A safeguarding report was submitted quarterly to the CCG and annually to the board of directors.

As a result of the acquisition, safeguarding arrangements were to be reviewed and revised to meet the requirements of the new organisation aiming to improve safeguarding practice by: establishment of a new safeguarding staffing structure based on need, establishment of a refined
governance structure to support safeguarding, harmonisation of safeguarding policies and procedures, maintenance of all safeguarding services throughout the period of safeguarding team transition and maintaining and strengthening key partnerships at a time of change and reorganisation of the trust.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The trust had a robust and effective framework in place to provide assurance around the quality of care it offered and to monitor organisational performance. The board of directors and executive director-level groups received regular performance reports which presented performance against national and local targets and priorities. These reports adopted a risk-based approach to reporting to ensure that the consequences of under-achievement were highlighted to the executive team and board of directors, as well as the actions that were in place to improve performance. The framework provided a good level of assurance and supported effective decision making.

In addition, the trust also had a clinical quality monitoring group and a care quality group in place led by the executive medical director and the executive chief nurse respectively. These groups reported to the board of directors and provided additional assurance and effective accountability around clinical quality and the patient experience.

This framework operated at multiple levels, but always with a clear line of sight from individual clinicians on the wards to the board of directors. The trust monitored quality and performance regularly and at many levels, with clear routes of escalation and delegation.

During our core service inspections, we found staff, at all levels, were clear about their roles, responsibilities and level of accountability. Matrons and heads of divisions met with teams regularly to review and support the areas of improvement and share best practice. Monthly meetings were encouraged within teams to ensure staff received regular updates and were provided with the opportunity to be engaged in organisation developments and share learning.

The trust’s approach to performance took place within an open learning culture which emphasised appropriate professional accountability for quality and performance. At ward level, real time quality dashboards were used so that clinical teams could monitor their performance and benchmark against peers. The divisional leaders attended key accountability meetings of the whole trust chief executive advisory group (CEAG), the chief operating officer’s group (COOG) and the clinical quality monitoring group (CQMG) at their respective sites. In addition, there were periodic divisional performance reviews between the executive and the divisional management teams. Other groups were in place to oversee important areas that contributed to overall performance included, workforce, finance, elective care, non-elective care and cancer.

The board of directors received a suite of reports at each of its meetings, including clinical quality, experience of care, operational performance and finance. The purpose being, to give both a comprehensive overview of performance, and to highlight any exceptions that needed to be escalated. This enabled the board to triangulate performance across its services. We reviewed the board papers for the previous three months and saw where the executive board had a robust approach to quality improvement and performance management.
An important feature of the trust’s approach to accountability for performance was the executive root cause analysis meetings chaired by the chief executive (CEO), at which specific cases of actual or potential errors were discussed in detail.

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£812.2m</td>
<td>£858.2m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£10.0m</td>
<td>£29.1m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£802.2m</td>
<td>£829.0m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£10.0m</td>
<td>£29.1m</td>
</tr>
</tbody>
</table>

Note: On the 1st April 2018 the University Hospitals Birmingham NHS Foundation Trust (UHB) merged by acquisition with the Heart of England NHS Foundation Trust (HEFT). The figures shown above cover UHB for 2016/17 and 2017/18, and then the combined Trust for 2018/19 and 2019/20.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust.

Please see the separate use of resources report for details of the assessment.

Trust corporate risk register

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their ‘worry list’. The trust board had sight of the most significant risks and mitigating actions were clear.

During the short period since acquisition, the trust had made significant progress in strengthening their risk management process to ensure it was embedded in practice. We found the process to be clear and well understood. Executive leads, we interviewed, felt the board had moved forward on risk management and had a good level of oversight and assurance. Throughout this inspection, the inspection team were particularly impressed with the level of oversight and responsiveness following concerns identified at our core service inspections. For example, concerns around staffing, culture, the environment and medicines optimisations had been included on the relevant risk registers.
An updated risk management policy (October 2018) had been approved by the board. We reviewed this policy and found it was clear in its purpose; to make clear the standards and accountabilities for the management of risk within the trust. There were three types of risk that the trust expected to be identified and managed:

- Strategic risks
- Project risks
- Operational risks.

Operational risks included for example, quality, staffing, information and communication technology (ICT) and health and safety.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. As part of the risk assessment process, risks were scored and graded in line with the trust’s risk assessment matrix. New risks with a score of 15 (red) or above were presented to the appropriate executive or divisional management team for approval within one month of being reported. All risks with a score of 15 (red) or above were reviewed monthly and risks with a score of 12 or below (amber and green) quarterly. Where a risk met the trust’s ‘risk appetite’ (target score) this was reviewed six-monthly. Strategic risks were reviewed quarterly by the board and recorded on the board assurance framework.

The trust has provided five separate specialty risk registers that highlight the highest risks at the trust. The specialty risk registers provided by the trust are as follows: director of communications, director of corporate affairs, director of partnerships, director of strategic operations, director of workforce of workforce innovation.

The table below highlights the highest 20 risks across all five of the specialty risk registers. The risks below all have a risk score of moderate to high.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>Specialty</th>
<th>Description</th>
<th>Current risk</th>
<th>Residual risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/11/2009</td>
<td>Director of strategic operations</td>
<td>Ability to recruit international fellows to maintain current workload due to restrictions on visas.</td>
<td>6 - Moderate</td>
<td>6 - Moderate</td>
</tr>
<tr>
<td>-</td>
<td>Director of partnerships</td>
<td>Delayed transfers of care due to social care/other provider delays/ discharge impacting on the Trusts ability to deliver the Trusts Annual Plan</td>
<td>12 - Significant</td>
<td>12 - Significant</td>
</tr>
<tr>
<td>-</td>
<td>Director of communications</td>
<td>Adverse media coverage due to unforeseen circumstances or events leading to negative internal or external publicity.</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>Date</td>
<td>Department</td>
<td>Issue Description</td>
<td>Risk Level</td>
<td>Impact Level</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Jun-17</td>
<td>Director of communications</td>
<td>RRGW006 There is a risk that the non-statutory inquiry into the malpractice committed by Ian Paterson reveals/identifies historic corporate failings/weaknesses within HEFT which might result in detriment to the reputation of HEFT and UHB as its successor organisation.</td>
<td>15 - Significant</td>
<td>15 - Significant</td>
</tr>
<tr>
<td></td>
<td>Director of communications</td>
<td>Congestion around the site</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Director of communications</td>
<td>Reputational damage caused by staff activity on social media</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>10/08/2016</td>
<td>Director of communications</td>
<td>(Information Governance) - Unauthorised access to clinical images</td>
<td>16 - High</td>
<td>1 - Low</td>
</tr>
<tr>
<td></td>
<td>Director of workforce and innovation</td>
<td>(Clinical Activity Impact) - Trust clinical operational activity levels and high service demand reduce clinical staff and support service staff with research roles capacity to dedicate time to research activities.</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>12/10/2016</td>
<td>Director of workforce and innovation</td>
<td>(Financial) Loss of income and increase in financial liability due to Apprenticeship Levy</td>
<td>Significant</td>
<td>Significant</td>
</tr>
<tr>
<td></td>
<td>Director of workforce and innovation</td>
<td>(Business Continuity) Inability to recruit sufficient numbers of appropriately skilled, trained and competent staff due to insufficient supply.</td>
<td>Significant</td>
<td>Significant</td>
</tr>
<tr>
<td>08/06/2016</td>
<td>Director of workforce and innovation</td>
<td>(Financial) - Reduction to education income tariff and HEE overall budget following the comprehensive spending review</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>10/10/2016</td>
<td>Director of corporate affairs</td>
<td>If the corporate records archive environment deteriorates further (including further episodes of flooding) the records may be damaged beyond repair.</td>
<td>Significant</td>
<td>Significant</td>
</tr>
<tr>
<td>Date</td>
<td>Director of Corporate Affairs</td>
<td>Issue Description</td>
<td>Severity</td>
<td>Impact</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------</td>
</tr>
<tr>
<td>30/10/2009</td>
<td>Director of corporate affairs</td>
<td>Failure to comply with legislation, conditions of the provider licence, terms of the constitution, terms of the NHS contracts or NHSI guidance.</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>30/10/2009</td>
<td>Director of corporate affairs</td>
<td>Failure to comply with regulatory requirements</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>22/05/2009</td>
<td>Director of corporate affairs</td>
<td>Failure to operate a safe place to work.</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>30/10/2009</td>
<td>Director of corporate affairs</td>
<td>Major disclosure of confidential data</td>
<td>Significant</td>
<td>Moderate</td>
</tr>
<tr>
<td>23/11/2016</td>
<td>Director of corporate affairs</td>
<td>(Information Governance) Insufficient data processing and data sharing clauses in contracts</td>
<td>16 - High</td>
<td>Low</td>
</tr>
<tr>
<td>23/11/2016</td>
<td>Director of corporate affairs</td>
<td>(Compliance and Regulatory) Compliance with Bribery Act 2010, and Failure by staff to disclose conflicts of interest on the register</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>20/06/2017</td>
<td>Director of corporate affairs</td>
<td>(Compliance and Regulatory) Failure to comply with the Competition and Markets Authority Order 2014</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>13/07/2017</td>
<td>Director of corporate affairs</td>
<td>(Compliance and Regulatory) Failure to comply with BS1 10008 with regards to the legal admissibility of scanned records where the originals have been destroyed.</td>
<td>8 - Moderate</td>
<td>4 - Low</td>
</tr>
</tbody>
</table>

(Source: P113- Trust risk registers)

NHS Improvement’s Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where ‘4’ reflects providers receiving the most support, and ‘1’ reflects providers with maximum autonomy. The trust was in segment two of the framework. This meant the trust was “offered targeted support – potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS Trusts) and/or formal action is not needed.”
There was a systematic programme of clinical (internal and national) and external audit to monitor quality, operational and financial processes. In the year preceding this inspection, approximately 140 clinical audits (excluding medicines audits) had been undertaken across the four hospital sites. Senior staff across the organisation were aware of outcomes relevant to their area.

Assurance for non-clinical audits was provided to the board through the audit committee. The audit committee met bi-monthly and was chaired by a non-executive director. We reviewed three sets of minutes from the audit committee and saw meetings were well attended with representation from both internal and external auditors. In addition, we saw where audit outcomes had been discussed including identifying where actions should be taken.

Analysis undertaken by the Care Quality Commission had identified the trust as; a maternity outlier for emergency caesarean section rates, an outlier in the National Hip Fracture Database and an outlier in the National Paediatric Diabetes Audit. For each outlier that had been identified we saw where a robust investigation had taken place that included appropriate identified actions in place.

The trust had a quality assurance lead who took on the practical responsibilities of the medicines safety officer and was supported by quality assurance technicians. Medicines alerts and recalls were received through the group and through the trust electronic incident reporting system and disseminated according to need. For medicines alerts where there were changes to the prescribing information for the medicine these were handled through the trust patient safety group.

The trust had used the NHS benchmarking tool to review their medicines optimisation performance and were part of the Shelford chief pharmacists clinical group. This looked at Carter metrics as well as issues relating to procurement.

The trust had a separate pharmacy risk register, detailing action plans and progress. Relevant items were included on the corporate risk register, this was reviewed monthly. Staffing was identified as a risk. As part of their approach to managing this risk we saw that the trust had established a bank pharmacy staff group which reduced their reliance on locum staffing and improved the continuity of service.

Clinical audits were undertaken in pharmacy. For example, missed antibiotic dose audits were carried out at the QE site, a targeted approach to wards with raised levels had demonstrated a reduction in missed doses.

Medication storage audits were also carried out. However, during our core service inspection, we found evidence of medicines not being stored appropriately. The chief pharmacist was aware of the concerns and told us a scoping exercise was in place to determine whether remote temperature monitoring of fridges was viable for the trust.

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity. A business continuity plan was in place to support the trust in anticipating risks for the purpose of reducing them or preparing for them.

Where cost improvements (CIP) were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Throughout our interviews with executive leads we were consistently told CIPs would not affect the quality of care provided at this trust, all the executive leads demonstrated a joint focus that ‘quality took precedence over finance’. Monthly monitoring of CIPs, including
quality impact, was undertaken at divisional level and reported through the clinical quality meeting. As of November 2018, the actual CIP delivered was £16.9m against a target of £21.1m.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust had the relevant roles in place to effectively manage information. This included:

- The information governance team who provided expert advice and guidance to all staff on all elements of information governance.
- Caldicott Guardian who had responsibility for reflecting patients’ interests regarding the use of patient identifiable information.
- Director of corporate affairs (Senior Information Risk Owner) who was responsible for the overall development and maintenance of information governance throughout the trust.

Integrated reporting supported effective decision making. The trust had innovative information systems and processes. These systems were used to drive and support internal decision making as well as system wide working and improvement.

The trust housed state of the art clinical informatics with an advanced electronic data system. It was also regarded as an exemplar for its clinical and non-clinical governance systems. The trust’s unique approach meant it could build a customised range of business intelligence systems to suit any healthcare organisation to help it understand the quality of care it delivers, its financial efficiency, market share and opportunities.

One of the advantages of the trust’s informatics capability was that it allowed the trust to benchmark its performance for individual disease groups and clinical specialties with other hospitals in Europe, the United States and beyond. The trust had access to the United States Hospitals’ Honor Roll and could compare its in-hospital mortality with the Honor Roll data.

The trust was funded to set up and provide informatics expertise to the West Midlands Quality Observatory which enabled clinical performance to be benchmarked across the region. This had been recognised by the Department of Health.

In 2017 the trust was one of 12 NHS trusts designated as an NHS Global Digital Exemplar by NHS England, providing access to up to £10m to invest in digital infrastructure and specialist training. The trust was also leading the digital work stream for the sustainability and transformation partnership (STP) across Birmingham and Solihull.

Key to the trust’s approach to quality and safety and ability to effectively manage performance was the partnership of quality and technological developments. As a Global Digital Exemplar, the trust had innovative and bespoke information systems, most notably its PICS (Prescribing Information and Communication System) real-time decision support software which, was unique as an NHS-developed and delivered system. PICS was a rule based decision support system which operated in all inpatient, outpatients and day case areas. It supported full e-prescribing and drug administration for both routine and chemotherapy treatments, requesting and reporting of laboratory investigations, clinical observations and assessments and extensive order communications, including imaging requests and internal referrals.
An extension of the PICS was performance dashboards. Dashboards at QE showed performance by ward for around 30 clinical quality indicators which came under eight headings: infection control, adverse events, medicines management, care, ward administration, patient experience, risk assessment and diabetes. The clinical dashboard allowed ward staff and managers to compare their performance to the overall trust performance, as well as measuring their own performance over time. The data was presented by ward and was refreshed every night, allowing ward staff and managers to see up-to-date information. The dials displayed performance for the last 30 days, while the tables showed data by calendar month and year-to-date performance. Every indicator had Red-Amber-Green thresholds which were set based on previous performance and agreed by the executive medical director and executive chief nurse. Users were able to drill down to patient-level data, with appropriate safeguards, to identify exceptions and look for patterns and trends.

A patient administration system ‘Oceano PAS’ which aimed to improve patient pathway management had been launched by the trust in 2017. Oceano PAS was the culmination of a four-year project to develop a patient administration system specifically to meet the needs of the trust. Its integrated functionality allowed for greater automation of tasks and aimed to improve data quality by limiting the scope for user error through a series of controls.

‘Myhealth@QEHB’ was a web-based system which had been developed by the trust to provide patients with chronic health conditions with high-quality information and support to allow informed choice and shared decision making. A secure patient portal allowed patients to access their health records securely online.

Information management played a key role in the trust’s strategy and organisational plan going forward and executive leads told us work was already underway to align informatics systems across the trust. This would mean a single hospital patient record across Birmingham and Solihull and would be instrumental in creating an alliance across health care providers.

The Model Hospital is a digital tool provided by NHS Improvement to support the NHS to identify and realise opportunities to deliver the best patient care in the most efficient way. NHS trusts are able to explore their comparative productivity, quality and responsiveness, to provide a clearer view of improvement opportunities. While some variation in trust activity is expected and warranted, the Model Hospital supports trusts to identify and tackle unwarranted variation.

The trust was not currently monitoring progress against the model hospital metrics. The trust had developed its own internal productivity tools which incorporated many of the metrics which were included in the model hospital. These tools enabled the trust to identify areas of improvement and specific efficiency targets were built into plans. For example, new to follow up ratios, theatre utilisation, length of stay and day case rates.

In addition to the trust’s internal benchmarking tools, GIRFT (Getting It Right First Time) and other external benchmarking tools were used to identify outliers. Delivery against the plan was monitored through the monthly chief operating officer group with detailed reviews taking place at, the operational delivery and financial improvement group. Subgroups led, managed and identified improvement work to ensure capacity was utilised as effectively as possible.

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital on 31 March each year. The purpose of the IG Toolkit is to provide assurance of an organisation’s information governance practices. On the basis of the
trust’s annual review, an overall assessment of ‘significant assurance with minor improvement opportunities’ was made. Records we reviewed confirmed this.

The board were aware of national risks, including cyber-security, and supported information management and technology colleagues to ensure appropriate strategies and systems were in place. In addition, a wide range of policies and procedures were in place to provide guidance and give assurance to the trust and individuals on information governance.

In response to recommendations from the Carter report 2016, the trust had carried out a digital maturity assessment across all four of its hospital sites. Results for the QE site rated the digital maturity index (DMI) as second of 239 (all acute NHS organisations) and the HGS site as 182 of 239. The DMI is an indicator of how well providers in England are making use of digital technology. The trust had plans in place to align information management services across the trust.

Key performance indicators (KPIs) for the medicines team in the trust were reported through four separate pharmacy speciality group reports which were reviewed at the trust wide clinical quality management group quarterly. Work was ongoing to establish the sending of discharge letters to community pharmacies to promote information sharing and medicine adherence in the community.

The chief pharmacist held the role of Controlled Drugs Accountable Officer (CDAO) and attended the regional controlled drugs local intelligence network. The trust shared information with the regional CDAO and the controlled drugs local intelligence network (CD-LIN) through quarterly paper-based reports.

The Accessible Information Standard (AIS) aims to ensure those with impairments or communication needs receive information relating to their healthcare in appropriate formats, and that they have access to appropriate support while attending the hospital.

To meet the requirements outlined by the AIS, the trust’s patient administration system (Oceano PAS) had been developed with the functionality to record patients’ communication needs and delivered prompts to users to flag where patients had recorded needs.

Incidents, including serious incidents, were reported as required to the NHS National Reporting and Learning System or the NHS Strategic Executive Information System in a timely way. The trust submitted notifications to the Care Quality Commission in line with their statutory responsibilities.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Public and patient engagement

The trust engaged and involved patients to shape services and culture. There were three Patient and Carer Councils at the trust, made up of members of the public, patients, carers and staff representatives. One council focussed on the wards, another on outpatients and the third was a Young Persons’ Council which looked at the experience of young adults age 16-24 who were using services. The councils generally met every six weeks or bi-monthly.
Council members attended meetings, visited wards and departments and were involved at the planning stage of developments or changes in service delivery in the hospitals. They were also invited to take part in the trust’s annual PLACE assessments.

Patient and Carer Councils reported to the trust Council of Governors. During 2017/18 the Patient and Carer Councils (PCC) were consulted on for example:

- The PCC Constitution
- Healthcare Evaluation Data
- The annual plan and quality priorities
- Patient experience
- Nursing priorities
- Research projects.

Outcomes and learning from these activities and others was reported to the board through the Council of Governors. The Patient and Carer Councils were proactive in driving change through the organisation. Changes included for example:

- The PCC constitution was altered to include members views
- Visiting times comments were reflected in the visitors’ charter
- End of life treatment bell - different options were considered (including where the bell might be sited)
- Researchers had changed research protocols to better capture quality of life in response to better understanding of patient experience of disease.

Additionally, the trust had a comprehensive ‘membership events schedule’ dated October 2017 to March 2019 that aimed to include people from a range of equality groups. For example, Hindu health awareness day and Muslim women’s health awareness day.

As a Stonewall Diversity Champion, the trust showed its support to transgender patients and staff and the wider community of transgender people in Birmingham and Solihull. The trust participated in Transgender Awareness Week in November 2018 to help raise the visibility of transgender and gender non-conforming people, and address the issues the community faced.

At the Queen Elizabeth site, ‘guide dog resting stations’ were in place at the main entrance. Dedicated staff would care for the guide dog whilst their owner visited a friend/relative or attended an appointment. Across the trust a deaf/blind passport was in place to facilitate a timely pathway through the Emergency Departments.

A ‘Pets in Hospital’ scheme had recently been introduced on the Queen Elizabeth site that saw specially assessed dogs visit patients at the hospital, helping to reduce their anxiety, and enhance patient communication and interaction. The scheme had been launched across the elderly wards, and patients were able to request a visit from one of the dogs through the nurse in charge.

The trust supported a team of volunteers to help staff deliver care to patients. The volunteers were part of the trust teams and complimented the work of paid staff to enhance the experience of patients, carers, visitors and staff. Volunteers were placed in approximately 75 departments throughout the trust. Examples of areas worked and roles held included:

- Ward helpers
- Outpatients Department
- Cardiac rehabilitation classes
- Patient and carer council
- Peer support groups
- Chaplaincy
- Patients library
- Buggy drivers
- Dignity volunteers.

A monthly newsletter ‘news@UHB’ was available for staff, patients and visitors at the trust.

There was a trust wide patient governors’ groups which the chief pharmacist attended, this shared patient experience and represented the views of patients and carers.

The trust pharmacy team also liaised closely with Birmingham children’s hospital to facilitate transfer of care for individuals who were transitioning form children’s services.

The trust medicines team offered face to face support for in-patients of the trust to provide guidance and information relating to their medicines.

**Staff engagement**

At the Heartlands, Good Hope and Solihull sites the staff engagement score in the 2017 NHS Staff Survey was slightly lower than the national average at 3.7 (average 3.8). Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. The staff engagement score at the Queen Elizabeth site for the same reporting period was 3.9 and slightly higher than the national average.

Steps had been taken to engage the workforce, such as for example, holding staff briefing sessions with the chief executive, a monthly newsletter, posters, pay slip leaflets and PC screensavers. In addition, the trust was committed to focusing on four key corporate priorities; staff wellbeing, staff recognition, leadership and flexible working / work-life balance.

Staff were recognised through the trust’s ‘Building Healthier Lives Awards’. These were the trust’s first staff awards since the acquisition in April 2018 and honoured individuals and teams who went above and beyond the call of duty to deliver excellent care. In November 2018, gold, silver and bronze awards were handed out in 14 categories at Good Hope, Solihull, Heartlands and Queen Elizabeth hospitals. The gold award winners were to go forward to a ‘grand final’ in March 2019 when the diamond winners would be announced.

As of June 2018, the flu vaccination uptake for the QE site was 72%, this was a 5% decrease on figures for the same time last year but similar to the national average. The flu vaccination uptake for the HGS sites was 74%, this was a 3% decrease on figures for the same time last year but similar to the national average.

The chief pharmacist and the senior team within the pharmacy department had representation on a variety of internal and external decision-making groups. The local medicines safety officer (MSO) group was attended by the quality assurance lead.

During our core service inspections, we spoke with approximately 750 staff. In addition, we held focus groups across all staff groups. Staff mostly felt actively engaged and that their views were reflected in the planning and delivery of services. However, there were ‘pockets’ where staff told us they felt disengaged (this was largely on the Solihull hospital site) and staff side representatives
felt there was a 'lack of engagement' between them and the senior executive team. They told us, communications involving for example, the recent acquisition, had not included this staff group.

There was a very active and visible ward based medicines team composed of pharmacist and technicians. Staff told us this was appreciated and made it easy to access timely medicines related information. Some wards at the Queen Elizabeth (QE) site were trialling using a pharmacy technician as part of the ward team for medicines administration. This was working well and other wards were interested in expanding this model.

**Stakeholder engagement**

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the local healthcare population. The trust was one of the leading organisations in the Birmingham and Solihull sustainability and transformation partnership (STP) and as such, actively engaged with 177 general practices, acute, mental health and community trusts and local clinical commissioning groups (CCG).

The trust actively engaged with NHS England and NHS Improvement to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs.

Engagement with NHS England Prescribed Services Specialised Commissioning included; membership of the major trauma network and the West Midlands Cancer Alliance.

The Trust was working closely with local hospices to develop models of care for people at end-of-life to prevent inappropriate hospital admissions and facilitate appropriate rapid discharge to enable people to die in their place of choice.

Additional stakeholder engagement included for example, local universities, the West Midlands Academic Health Science Network, West Midlands Genomics Medicine Centre and the Ministry of Defence.

The chief executive chaired the Birmingham and Solihull (BSOL) A&E Delivery Board. This forum included the chief operating officers for HGS and QE hospitals, director of partnerships, a number of external stakeholders and the local NHS ambulance trust and the NHS 111 service.

We reviewed a selection of meeting minutes from a number of external stakeholder meetings including for example, CCG contract meetings, STP meetings and meetings with Birmingham City Council. Meeting minutes demonstrated there was transparency and openness with all stakeholders about performance.

There were strong links with the local area prescribing committee which met monthly with representation from local hospitals, other trusts, CCGs and general practice. The chief pharmacist linked with local chief pharmacists and was part of the Shelford chief pharmacist group to share good practice.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect.

**Heart of England NHS Foundation Trust (provided for contextual purposes)**

For the 12-month period from April 2017 to March 2018, HSMR was as expected with a value of 101.61 (compared to 100 for England) and 2,830 deaths compared to an expected 2,785 deaths. Weekend HSMR was higher than expected for this time period.

**University Hospitals Birmingham NHS Foundation Trust**

For the 12-month period from April 2017 to March 2018, HSMR was as expected with a value of 104.53 (compared to 100 for England) and 1,561 deaths compared to an expected 1,493 deaths. Weekend HSMR is within expected range for this time period.

**HSMR Post Acquisition April 2018 to July 2018**

<table>
<thead>
<tr>
<th>Facility</th>
<th>HSMR</th>
<th>No of deaths</th>
<th>Expected no of deaths</th>
<th>Higher/lower than expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital Birmingham (QE)</td>
<td>105</td>
<td>1332</td>
<td>1265</td>
<td>Higher</td>
</tr>
<tr>
<td>Heartlands, Good Hope, Solihull (HGS)</td>
<td>113</td>
<td>395</td>
<td>347</td>
<td>Higher</td>
</tr>
</tbody>
</table>

The trust had one active mortality alert at QE: Septicaemia (except in labour). The trust had recently been notified of this alert formally by the Care Quality Commission. However, the trust was already aware through their own analysis of data. We were told the case-list for this mortality outlier was currently under review by the associate medical director.

**Learning from Deaths**

The trust had a process in place for reviewing all inpatient deaths in line with the National Quality Board’s ‘Learning from Deaths guidance. A ‘Reviewing Inpatients Death Policy’ detailed the requirements for trust medical examiners and individual clinical specialties to review inpatient deaths in line with national guidance and requirements. A ‘Procedure for Reviewing Inpatient Deaths’ set out the framework for reviewing inpatient deaths across the trust.

Any unexpected death with obvious care concerns or harm would be expected to be reported through the trust’s electronic incident reporting system. All deaths of patients with a learning disability were subject to a mortality review. Death reviews were undertaken by a medical examiner using the National Mortality Case Record Review Programme (NMCRR) structured review tool.

All deaths meeting the trust’s escalation criteria for a ‘stage 2’ review were discussed at specialty mortality and morbidity meetings. Outcomes of all deaths escalated for further review were presented to the clinical quality monitoring group (CQMG). Outcomes of reviews of deaths were reported to the board of directors on a quarterly basis. This included, as a minimum, the number of deaths occurring in the trust, the number reviewed, and the number attributable to shortfalls in care.

A summary of all inpatient deaths between 1 Jul 2018 and 30 September 2018 was presented to the board of directors in October 2018:
<table>
<thead>
<tr>
<th>Total no of deaths</th>
<th>Total deaths reviewed</th>
<th>No of deaths considered ‘potentially avoidable’</th>
</tr>
</thead>
<tbody>
<tr>
<td>1049</td>
<td>795</td>
<td>4</td>
</tr>
</tbody>
</table>

Of the four potentially avoidable deaths, one related to a patient with severe learning disabilities. In response to concerns raised by the medical examiner this case had been reviewed at the ‘Clinical and Professional Review of Incidents Group (CaPRI) in September 2018 and was currently being investigated as a serious incident.

Bereavement services provided support to families and carers of patients who had died whilst in the care of the trust.

Members of the investigation team would maintain contact with families and carers and offer them the opportunity to meet and discuss their concerns or answer any questions they may have where a case requires a serious incident investigation.

Learning disability specialist nurses assisted medical examiners by informing them of any patients, who had a learning disability, who had died whilst in the care of the trust.

As part of this inspection we interviewed the team responsible for reviewing deaths and, looked at the trust’s processes. The inspection teams’ overall opinion was of a well-led, strategically driven service. We reviewed three death reviews and found robust investigations had taken place with evidence of lessons learned and actions taken. Governance arrangements were robust and the board of directors had good oversight of all deaths across the trust. We saw where families / carers had been engaged with investigations however, we were not assured they were involved in service change as a result of an avoidable death.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months. Performance is based on the period April 2017 to March 2018.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance (as at March 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>30 working days</td>
<td>85% within 30 working days (QEHB) 90% within 30 working days (HGS)</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30 working days</td>
<td>85% within 30 working days (QEHB) 90% within 30 working days (HGS)</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Question</td>
<td>Number of complaints</td>
<td>Time period</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months? - QEHB</td>
<td>1,260</td>
<td>01/04/2017-31/03/2018</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months? - HGS</td>
<td>1,745</td>
<td>01/04/2017-31/03/2018</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

**Number of complaints made to the trust**

The trust received 1,793 complaints from April 2017 to March 2018. Outpatients received the most complaints with 801.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Outpatients</td>
<td>801</td>
<td>44.7%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>351</td>
<td>19.6%</td>
</tr>
<tr>
<td>AC - Medical care (including older people's care)</td>
<td>201</td>
<td>11.2%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>188</td>
<td>10.5%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>179</td>
<td>10.0%</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
<td>1.3%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>14</td>
<td>0.8%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>11</td>
<td>0.6%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>9</td>
<td>0.5%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>9</td>
<td>0.5%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>4</td>
<td>0.2%</td>
</tr>
<tr>
<td>CHS - Sexual Health</td>
<td>3</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,793</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

One complaint was also received for breast screening, which sits outside of the inspection framework as it is part of a national screening programme.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

All complaints were ‘triaged’ by the divisional heads of nursing to determine who should lead the investigation based on the content of the complaint and how the trust should respond. For example, a complaint about the cancellation of an appointment may be promptly resolved by a telephone call from a divisional manager to the patient offering a new appointment date. There was a dedicated complaints officer who managed the complaints for each division. They liaised closely with divisional colleagues by phone, email and in person to secure reports, draft responses and arrange meetings.

The investigation was documented in the information sent from the division to the complaints officer. This was held electronically in individual electronic folders for every complaint. Historically, correspondence was printed and placed on the paper complaints file held within the complaints department. Progress with the investigation was also recorded on an electronic database and regular reports were produced from this information. The response was drafted by the relevant complaints officer and reviewed by the head of patient relations, head of patient experience or
assistant patient relations manager (complaints); the revised version was sent to the contributors for review and the senior divisional management team for divisional sign off. It was then further reviewed by a senior member of the corporate nursing management team before going to the executive chief nurse for final review and sign off on behalf of the chief executive.

Responses to complaints including any learning from the complaints investigation were shared with ward/department colleagues at team meetings. Individual actions from complaints were captured on the electronic database and reported quarterly to divisional management at the divisional clinical quality group meeting. Themes and trends from complaints and related learning was shared in the reports. Learning from complaints was also shared within the 'Learning and Sharing' document which is distributed to all staff through the team brief.

The head of patient relations had regular meetings with divisional heads of nursing to discuss their complaints and the overarching themes, trends and associated actions. Comprehensive training was delivered around complaints where themes and associated learning had been highlighted.

Changes to clinical practice as a result of a complaint included for example, when a ward patient missed a chemotherapy session due to nursing handover not being fully completed, the paper process had been updated so that the majority of chemotherapy rotas were now prescribed on the trust computerised medication charts. This system created an alert when drugs were overdue and enabled nursing and medical teams to check that all prescriptions were given prior to a patient’s discharge. Another change related to a patient who had to go to the cardiac catheterisation laboratory for a procedure and had to walk through a public area of the hospital in just a gown. As a result of the complaint patient letters had been amended to advise patients to bring in slippers and a dressing gown to ensure their dignity was maintained.

We found the board had a good oversight of complaints. An overview of complaints including; new, re-opened and follow-up complaints and responses within 30 working days was presented to the board of directors quarterly by the executive chief nurse through the clinical quality meeting (CCQ). We attended a CCQ during this inspection and saw there was a good understanding of complaints from both executive and non-executive directors.

The inspection team reviewed two complaints during this inspection and saw where people’s concerns and complaints had been listened and responded to appropriately and used to improve the quality of care. However, the timeliness of responses to both complaints was worse than the trust target of 30 days at 82 and 84 days respectively.

Compliments

From April 2017 to March 2018, the trust received a total of 2,162 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical care (including older people's care)</td>
<td>727</td>
<td>33.6%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>627</td>
<td>29.0%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>214</td>
<td>9.9%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>148</td>
<td>6.8%</td>
</tr>
<tr>
<td>CHS - Sexual health</td>
<td>148</td>
<td>6.8%</td>
</tr>
<tr>
<td>Other</td>
<td>96</td>
<td>4.4%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>68</td>
<td>3.1%</td>
</tr>
<tr>
<td>Provider wide</td>
<td>51</td>
<td>2.4%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>43</td>
<td>2.0%</td>
</tr>
</tbody>
</table>
Two compliments were also received for breast screening, which sits outside of the inspection framework as it is part of a national screening programme.

Information about compliments and themes was shared with the trust board through a quarterly report, which is subsequently provided to the CCG.

(Source: Routine Provider Information Request (RPIR) – Compliments)

Patient safety

The trust set out the following quality improvement priorities for 2018/19:

- Reducing grade 2 pressure ulcers
- Improve patient experience and satisfaction
- Timely and complete observations including pain assessment
- Reducing missed doses
- Reducing harm from falls
- Timely treatment for sepsis

Performance against the priorities was regularly reviewed and any barriers to achieving the priorities were discussed at the appropriate forum such as the clinical quality monitoring group. A mid-year progress report was provided to the board of directors and council of governors. This was also shared with the Birmingham and Solihull CCG and published on the trust’s website.

We reviewed the trust incident reporting system and found the trust had a robust process in place to ensure that there was learning from incidents across the trust.

At a local level there was a requirement within the trust incident reporting system, for those who were responsible for reviewing the reported incident and identifying actions in response to the incident (the incident handler), to confirm that feedback was provided to staff. There was a project meeting in place to align the QE and HGS incident reporting systems. The incident handler was also able to email a summary of the actions taken directly to the person who reported the incident and any other staff involved. Staff were also provided with feedback on incidents at ward/team meetings.

Where there was a serious incident investigation it was a mandatory requirement for feedback and learning from the incident to be provided to the staff. Evidence was provided to the risk and compliance team to show that the action had been completed. Any actions that were not completed were monitored by the clinical governance and patient safety team and escalated to the director of corporate affairs, executive chief nurse and medical director.

Trust wide and divisional learning was facilitated in a number of ways:
- Aggregated report on incidents, complaints, claims and PALS data that was reported to the care quality committee. The purpose of the aggregated report was to assist the trust in learning from incident data, complaints and claims.
- Incident reports provided to the divisional clinical quality groups, clinical quality monitoring group and care quality group.
- Distribution of safety alerts through the electronic incident reporting system.
- Introduction of quarterly ‘SIs at a glance’. This was a quarterly newsletter that was shared with staff through the intranet and staff communication which provided a summary of learning from any serious incident investigations.

There was a strong focus on research and innovation which supported local, national and international best practice.

The trust was host to the UK’s only National Institute for Health Research (NIHR) Surgical Reconstruction and Microbiology Research Centre (SRMRC).

The trust was the lead organisation for the West Midlands Genomic Medicine Centre (WM GMC), which was one of 13 centres delivering NHS England’s pioneering 100,000 Genomes Project. In November 2018, one of the final families was recruited to take part in the project before whole genome sequencing moved into routine NHS care.

The trust had a purpose-built, dedicated unit; The NIHR / Wellcome Trust Birmingham Clinical Research Facility (CRF) where study participants took part in research programmes safely according to robust, ethically approved trial protocols. The CRF was a collaboration between the University of Birmingham, University Hospitals Birmingham NHS Foundation Trust and Birmingham Children’s Hospital NHS Foundation Trust. Current research trials included for example:

- Seated Physical Activity in Ageing (SPAA)
- Onset and Functional Consequences of Left Ventricular Myocardial Fibrosis in Early Stage Chronic Kidney Disease
- Real-world treatment patterns and outcomes in relapsed/refractory cutaneous T-cell lymphoma following systemic therapy in Germany, France and the UK: A chart review study
- A Phase 1 Randomized Double-Blind Placebo Controlled Study to Evaluate the Safety, Tolerability Pharmacokinetics and Pharmacodynamics of Single Ascending Doses of NGM217 in Adults with Autoimmune Diabetes

In September 2016, the trust was named as a Global Digital Exemplar trust as part of new plans to fast-track digital development and improve the digital skills of the NHS workforce. Throughout this inspection the executive team demonstrated a tremendous passion for their work in this field and told us of plans to align services not only across the trust but in the wider healthcare population.

The trust was a primary receiving hospital for military personnel injured overseas. The Royal Centre for Defence Medicine (RCDM), worked in partnership with the trust and a number of other NHS hospitals in the Birmingham area to support the operational patient pathway, with the majority of casualties receiving treatment at the QE.

The trust played a significant role in the Birmingham and Solihull Sustainability and Transformation Partnership (STP), taking a leading role on digital technology.

The trust was one of a group of trusts nationally who had participated in the Clinical Utilisation Review (CUR) CQUIN. CUR was adopted as national NHS policy in 2006. Through the deployment of one of the nationally accredited CUR applications, commissioners and providers
are able to make objective, evidence-based assessments of whether patients are receiving the right levels of care in the right setting at the right time. The trust was the only trust nationally to have eradicated the need for qualified nursing staff to enter data into the CUR application. Through the adoption of Robotic Process Automation, the trust had pioneered a reliable and consistent methodology for completing daily CUR assessments on inpatient wards, releasing around 40 minutes per day of time to care on every ward. The trust had shared learning from the project at the National CUR Learning Network and was working with the national CUR team on a case study.

The chief pharmacist and the staff we spoke to described a recent innovation in the Clinical Decisions Unit (CDU) with a pharmacist present 24-hours a day. This was currently in action at QE with plans to roll out across the trust as the benefit was demonstrated. There was not initially felt to be a value in having the team in the Emergency Department (ED) but ED consultants were now engaging more with the pharmacists on CDU so patients accessing ED without reaching the CDU were also benefitting.

The trust ran an annual ‘best in care’ award and the care home support provided from the medicines team at HGS was recently nominated and achieved the bronze award. This service was provided by trust staff and was managed from the HGS sites but was funded through the local clinical commissioning group (CCG).

The chief pharmacist described the trust as being on a new journey and it was imperative that they took the time to understand the culture and processes at the merged sites before significant change was implemented. The intention was to use the ‘best of the best’ from each site and not lose good work in the drive to align processes.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Services accredited</th>
<th>Core service or clinical area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy service at QEHB. Endoscopy Unit Solihull Hospital – 1st April 2018 Endoscopy Unit Birmingham Heartlands Hospital – 1st April 2018</td>
<td>Medical Care</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</td>
<td>The following services at QEHB: Haematology: 03/07/18 Biochemistry: 19/06/18 Microbiology: 30/10/17 Molecular Pathology: 27/02/18</td>
<td>Pathology</td>
</tr>
<tr>
<td>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</td>
<td>The following services at QEHB: Audiology granted re-accreditation on 27/04/18. Vascular Science, Lung Function and Sleep and GI Science were recommended for accreditation on 16/03/18. This is currently with a decision maker at IQIPS for final approval (expected September 2018).</td>
<td>N/A</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>QEHB has received ISO: 9001 accreditation which is equivalent to CHKS</td>
<td>N/A</td>
</tr>
<tr>
<td>QPIDS Accredited services</td>
<td>University Hospitals Birmingham NHS Foundation Trust (accredited under the UKPIN accreditation scheme) have been assessed and have been shown to meet the QPIDS standards, and so have been granted accreditation. Birmingham Heartlands, Good Hope and Solihull: Immunology Service (Adults and Paediatrics) are due to be inspected for re-validation in October 2018. Pre-inspection portfolio has been submitted.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services Queen Elizabeth Hospital

Urgent and emergency care

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Details of emergency departments and other urgent and emergency care services

- Queen Elizabeth Hospital – Emergency department and clinical decision unit (CDU)
- Birmingham Heartlands Hospital – Emergency department and ambulatory care
- Good Hope Hospital – Emergency department and ambulatory care
- Solihull Hospital – Ambulatory emergency care

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The emergency department at Queen Elizabeth Hospital serves the local population of South Birmingham as well as regional and national services for liver, renal, cardiac, oncology, haematology, neurosurgery, vascular stroke and other specialties. It also hosts a multidisciplinary team of professionals including colleagues from the Royal Centre for Defence Medicine and theatres.

A clinical navigator is based in minors and triages all ambulant patients presenting in minors to the correct stream to ensure the patient is seen in the correct stream for their clinical needs.

(Source: Acute PIR – Context acute QEB / Context acute HGC tabs)

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From August 2017 to July 2018 there were 216,385 attendances at the trust’s urgent and emergency care services as indicated in the chart above. Of these 201,607 were type 1 and 14,778 were type 3.

Please note: This includes attendances for April to July 2018 which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.
We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The percentage of A&E attendances at this trust that resulted in an admission increased in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for
qualified nursing staff in urgent and emergency care at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Major incident planning</td>
<td>170</td>
<td>170</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>35</td>
<td>35</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>155</td>
<td>168</td>
<td>92.3%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire training</td>
<td>156</td>
<td>170</td>
<td>91.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>154</td>
<td>169</td>
<td>91.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>124</td>
<td>138</td>
<td>89.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>108</td>
<td>132</td>
<td>81.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall training compliance rate of 91.9% for qualified nursing staff. The trust’s training targets were met for four of the seven mandatory training modules for which qualified nursing staff were eligible. All modules had completion rates of over 80%.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in urgent and emergency care at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Major incident planning</td>
<td>64</td>
<td>64</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>52</td>
<td>65</td>
<td>80.0%</td>
<td>95.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection control</td>
<td>51</td>
<td>64</td>
<td>79.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>17</td>
<td>22</td>
<td>77.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire training</td>
<td>49</td>
<td>64</td>
<td>76.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall training compliance rate of 83.5% for medical staff. The trust’s training targets was met for one of the five mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The mental health liaison team, based in the clinical decision unit (CDU), provided additional mental health support by providing staff with regular formal and informal training around different areas of mental health. This included training on psychosis, personality disorder and the Mental Health Act. A new package of training around supporting staff to understand patients’ mental health needs was under development at the time of our inspection.

Safeguarding

Though the trust has reported figures for safeguarding level 1 training, it should be noted that the trust has not designated this as mandatory training.

Queen Elizabeth Hospital

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in urgent and emergency care at Queen Elizabeth Hospital is shown below:
In urgent and emergency care, the hospital had an overall safeguarding training compliance rate of 91.9% for qualified nursing staff. The trust’s 90% completion target was not met for the level 2 training module.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in urgent and emergency care at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1</td>
<td>64</td>
</tr>
<tr>
<td>Safeguarding level 2/DoLS and mental capacity</td>
<td>6</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall safeguarding training compliance rate of 84.3% for medical staff. The trust’s 90% completion target was met for one of the safeguarding training modules for which medical staff were eligible, with the level two training having a completion rate of just over 30%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Processes were in place to assist staff in obtaining urgent specialist referrals for patients they suspected were at risk or victims of child sexual exploitation or female genital mutilation. These policies were readily accessible on the trust intranet with additional information from senior staff regarding rapid support from community teams.

Allied health professionals (AHPs) were trained to safeguarding level 2 or level 3 and those working the emergency department (ED) and CDU were up to date in their training.

Following the publication of the 2018 Intercollegiate Document on level 2 safeguarding training for the Healthcare Practitioner Induction Programme for all qualified staff commencing employment, the trust evaluated safeguarding training provision and enhanced this to level 3. In October 2018 100% of required staff had up to date safeguarding level 1 training, and 95% of required staff for each of safeguarding levels 2 and 3 had up to date training. In the CDU team, 94% of required staff had up to date safeguarding adults and children level 2 training and 92% of required staff had up to date level 3 children training. In the ED, all teams met or exceeded the trust’s 90% target completion rate.

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 knew where to access trust safeguarding policies and how to access more senior support.

The dedicated safeguarding team provided on-demand support for patients and staff, including in urgent reviews for patients and guidance in carrying out assessments for staff. This team maintained up to date, comprehensive information for staff online, including signposting to escalate immediate concerns such as homelessness, neglect or domestic abuse.
Staff had access to 24-hour, seven-day mental health liaison support. All staff could make referrals to the rapid assessment interface discharge (RAID) team who were based in the hospital for any patients aged 16 years and over with presumed mental health or substance misuse needs. Staff we spoke with knew how to make a referral and did so when appropriate.

The RAID team were employed by another NHS trust were commissioned to provide mental health support, advice and liaison with external teams. The RAID team comprised consultant psychiatrists, registered mental health nurses, a team manager, an administrator and a medical secretary. Staff within the team reported high vacancies and that this impacted greatly on their ability to meet their targets and their use of bank staff.

**Cleanliness, infection control and hygiene**

Antibacterial hand gel and personal protective equipment (PPE) was available in all clinical areas, including side rooms and bed spaces. Posters encouraged visitors to use hand gel and to wash their hands before entering clinical spaces. During all our observations clinical staff observed the trust’s bare below the elbows policy and followed good hand hygiene guidance, including between patient examinations and when entering clinical areas. Staff observed aseptic non-touch technique (ANTT) guidance when carrying out procedures and consistently and correctly used PPE.

All clinical areas were visibly clean and we saw a continual presence of domestic and housekeeping staff. This team used established protocols for cleaning treatment bays and waiting areas and responded quickly to requests for deep cleans and decontamination.

In all areas we checked sharps were stored, handled and disposed of in line with the Health and Safety Executive Sharps Instruments in Healthcare Regulations 2013, such as properly assembled and labelled sharps disposal containers. However, it was common practice to leave temporary lid closures open. This was the case in 21 of the 29 sharps bins we looked at, which presented a risk that children or those with limited capacity could injure themselves.

Staff had access to brightly coloured ‘I am clean’ stickers to identify when an item of equipment had been cleaned and decontaminated and was ready for use. We did not see it was common practice to use this system. Reminder posters were in place in sluice areas to remind staff to use the stickers to demonstrate when commodes had been sanitised. However, use of the stickers was inconsistent and in the CDU sluice room staff had not labelled any of the commodes drying above the wash area. This meant there was no system of assurance in place.

Staff carried out hand hygiene audits monthly and the ED team demonstrated consistently good standards, with 98% compliance in September 2018.

A housekeeping team kept the patient and public toilets clean and tidy and checked these regularly according to documented schedules.

From April 2018 to October 2018 staff reported seven incidents relating to infection control, which reflected less than 1% of the total incidents reported. In each case senior nurses investigated the incidents and worked with staff to identify opportunities for improvement.

In the 2018 patient-led assessment of the care environment (PLACE) the ED and CDU scored the maximum 100% for the cleanliness measure.

**Environment and equipment**

The waiting room for the main ED was cramped and regularly ran out of seating space for patients. On one day of our inspection patients were sitting on the floor, blocking access for
trollies and wheelchairs. Reception staff said they felt the queuing system was not fit for purpose and demonstrated how it contributed to increased patient frustration when the department was very busy. For example, the sign instructing patients to wait in a certain area was not visible from the main entrance, which resulted in increased tensions when patients already waiting thought others were trying to push in front of them. They said they had escalated this as a concern to the senior team but had not received feedback.

A charge nurse lead for major incidents was in post in the ED and led the department in major incident planning and policy. Learning from training and discussions with staff had led to the implementation of a new policy. This was a more user-friendly document that was more concise and accessible for staff who would only rarely come across it. Major incident and evacuation policies were up to date and processes were in place for senior nurses to establish lead coordination roles in the event of an emergency. The charge nurse lead had developed high-visibility action cards for each key role in an emergency, such as the nurse in charge, which would help staff maintain actions in line with the policy and their training.

The ED was equipped with equipment for use in a chemical, biological, radiological or nuclear (CBRN) scenario and training was mandatory for all staff. In addition to the ED team, 20 porters were trained in the set-up of CBRN equipment, including decontamination sets and dignity gazebos. Learning from a previous major incident simulation exercise had led to a change in policy, which meant the fire service would take a lead role in setting up decontamination equipment. This would release nurses to remain in their clinical roles. Another major incident simulation was planned and would include the hospital ambulance liaison officer (HALO) in a key role. CBRN training was ongoing and at the time of our inspection 43% of staff had been trained. The lead ED practice development nurse (PDN) said plans were in place to increase this, including through the recruitment of staff nurses who could deliver training.

Two staff had completed train the trainer sessions in the use of powered respiratory protective suits (PRPS) for use in a major incident and plans were in place for another four staff to complete this. The ED had 24 live decontamination suits and 20 major incident grab bags, one for each cubicle. A catastrophic haemorrhage kit was available and all major incident equipment matched that commonly in use on a daily basis. This meant staff were already trained in its use.

Fire risk assessments had been carried out in the CDU and ED in April 2018. The assessments highlighted that staff were not trained to use fire extinguishers, which presented a risk of injury if they attempted to do so in an emergency. The risk assessment for the CDU highlighted seven areas that needed action in relation to the environment and the ED assessment highlighted two risks, all of which the matrons addressed. The acute medical centre (AMC) had undergone a fire risk assessment in March 2018 and there were no unmitigated risks found. Similarly, there were no defects found in the emergency observation unit (EOU) in an October 2018 fire risk assessment although it was noted in all areas completion of fire safety training was below trust minimum standards.

The emergency planning officer reviewed the outcomes of fires or emergencies in other hospitals and public spaces and used learning from these to ensure local procedures were up to date and fit for purpose. There was evidence of learning from incidents relating to security and the environment in the ED. For example, following a series of incidents in which fire alarms or door release alarms were activated accidentally, the emergency planning officer arranged for covers to be fitted to each alarm. This prevented non-intentional activation of the alarms. Although this demonstrated learning from specific incidents we were not assured of the oversight from a senior trust level of fire safety in the ED. For example, the emergency planning officer could not confirm if outcomes from the most recent fire risk assessment in April 2018 had been followed up and was not aware of current risks in the service.

Not all areas complied with the Control of Substances Hazardous to Health Regulations 2002. For example, a sluice room in the ED contained an unlocked cupboard with chemical cleaning
products, which presented a risk in the event of unauthorised access.

Each clinical area had a cardiac arrest trolley and staff were required to document a daily safety check on the equipment and expiry date of perishable items, including emergency medicine. We reviewed the checks for the three months leading to our inspection for the equipment in CDU. During this period staff had consistently documented checks, with one day missed in the period. Staff had not recorded checks for five days in the previous six weeks on the trolley in the EOU.

Staff did not consistently document safety checks on equipment in the resuscitation area. Staff were unable to locate the current folder of evidence of resuscitation equipment checks and out of the most recent 16 days, nine days had missing checks including six consecutive days without a documented check. On days that staff had documented checks, there were gaps relating to individual equipment, such as the hypoglycaemia box and ventilators. This meant the service could not be assured resuscitation equipment was always serviceable and ready for use.

The clinical engineering team maintained oversight of the electrical safety and portable appliance testing (PAT) of equipment in each clinical area. We checked 37 items of equipment in the ED, EOU, CDU and AMC including defibrillators, rapid infusers and infusion pumps.

The resuscitation team had not maintained the trust policy of quarterly resuscitation equipment safety checks due to a lack of capacity in the team, which meant there was no assurance of continual oversight. From April 2018 to August 2018 11 resuscitation trollies had not been included in the audit, including paediatric equipment.

In the 2018 PLACE assessment, both the ED and the CDU scored the maximum 100% for the condition, appearance and maintenance of the environment.

Assessing and responding to patient risk

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust scored worse than other trusts for one of the five Emergency Department Survey questions relevant to safety and about the same as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.2</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>
(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust has submitted the below figures for the median time from arrival to initial assessment for August 2017 to March 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>University Hospitals Birmingham NHS Foundation Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Sep-17</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Oct-17</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Nov-17</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Dec-17</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Feb-18</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Mar-18</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Apr-18</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>May-18</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Jun-18</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Jul-18</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

Data from April 2018 was still being submitted using the trust code for Heart of England NHS Foundation Trust up to (and including) July 2018.

(Source: NHS Digital - A&E quality indicators)

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From August 2017 to July 2018 there was an upwards trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Queen Elizabeth Hospital, rising from 65.8% in August 2017 to 70.3% in July 2018.
A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From April 2017 to March 2018 the trust reported 218 “black breaches”. There is an overall upwards trend, with spikes in September 2017 (42 black breaches) and January 2018 (48 black breaches).
Queen Elizabeth Hospital

From April 2017 to March 2018 the hospital reported 26 “black breaches”. No breaches were reported for five of the 12 months and a high of nine was reported in March 2018.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tabs)

Information received from the trust following our inspection showed, between April and November 2018, 90.7% of ambulances were handed over within 30 minutes.

We reviewed the initial triage documentation of 39 patients who presented in the ED on one day of our inspection. In each case staff documented a full set of observations, including a report of allergies and medical history. The average time from arrival to triage in our sample was 17 minutes, which reflected a wide performance range from zero minutes to 91 minutes. During our inspection we saw there was sufficient prioritisation of patients who deteriorated in the department. There was sufficient oversight of the waiting room.

Trauma attendances were well organised with all specialties in attendance and a clear leadership
structure within the team attending each patient. The team carried out swift assessments and transferred patients for imaging in line with national guidance.

Staff demonstrated good standards of emergency response when a patient collapsed in the waiting area, including an immediate assessment using best practice principles of advanced life support.

The resuscitation team delivered an on-going sepsis training programme to all ED staff, including AHPs, to improve early recognition of the condition and deteriorating patients. This team was working with CEs to adapt the trust sepsis tool specifically to the ED.

Consultants used an overriding system that enabled them to see patients who presented frequently with conditions usually treated by nurses or AHPs. This ensured patients with underlying conditions or problems were seen by senior clinicians when treatment from other professionals had not resulted in improvement.

All clinical staff had access to, and were trained to use, a mental health triage assessment when patients presented with a suspected mental health need. This included frameworks to assess suicide risk and a ‘red, amber, green’ (RAG)-based structure to help staff identify contributing risk factors such as problems with social care, housing or drug or alcohol use.

Staff used brightly-coloured sepsis assessment stickers as part of an inhouse, consultant-developed early warning alert system to indicate on documentation when a patient had undergone an assessment. A consultant and senior staff nurse were dedicated leads for sepsis in the ED and were proactive in the development and implementation of policies, training and practice. This team worked with the wider trust team including the site sepsis lead, divisional sepsis lead, microbiology consultant and antimicrobial pharmacist to ensure staff followed trust policy and national Sepsis 6 guidance when screening patients. The consultant sepsis lead maintained a meticulous rolling audit programme that measured compliance with sepsis standards every 10 days. The consultant tracked screening rates and in the three months leading to our inspection an average of 86% of patients had a screen fully compliant with trust standards. The audit included standards for prescribing prophylaxis within one hour of a positive sepsis screen. In the same period staff met this standard in 87% of cases, reflecting a range from 81% to 92%.

The x-ray team and the consultant of the day in ED led a safety system that meant all x-ray results were reviewed and followed-up on the same day. This reduced the risk of missed diagnoses and meant all patients were cared for within a fail-safe system.

Staff in the ED used a safety checklist that incorporated a number of risk assessment tools on a progressive basis per hour of admission to monitor patients for changes or deterioration. Checks increased based on the time following admission, from two hours to 12 hours. Staff had fully completed checklists in all 44 examples we looked at during our inspection in the ED, AMC, EOU and CDU. Documented checks included skin assessment, pain score, falls assessment and confirmation food and drink had been given or offered.

Due to a lack of capacity and significant demands on the service, staff used a corridor to accommodate patients on trollies who arrived by ambulance whilst they were waiting to be seen in the main department. Although this did not provide an appropriate environment, a registered nurse and a healthcare assistant (HCA) were dedicated to these patients and provided continual care and oversight. A dedicated cubicle was always available, should a patient on the corridor require interventions or discussions with medical professionals.

Staff used an electronic standardised early warning scores (SEWS) system to assess patients for deterioration. We looked at a sample of 39 SEWS records in the ED and CDU. In each case staff had taken appropriate action and liaised with clinicians or response teams. Staff used the national
standard Sepsis 6 pathway to assess patients for sepsis risk, which we saw consistent evidence of in our notes review.

Staff nurses held intermediate paediatric life support and senior staff nurses and senior nurses held advanced paediatric life support training. CEs delivered advanced emergency training for staff, including an emergency assessment simulation experience.

Nurses appropriately assessed patients presenting at the ED who were at risk of self-harm or suicide. CDU staff used the provider’s mental health triage assessment tool, which included a brief assessment of the patient’s history and current presentation and a resulting red-amber-green coding system and action plan. If required, ward staff then made a referral to the RAID team to come and assess the patient within a one-hour timeframe. The RAID team were unable to assess patients until the patient was deemed to be medically fit. CDU staff reported this caused delays in patients getting access to the required mental health support.

During their assessment, the RAID team or the mental health liaison team made recommendations about the patients’ observation levels dependent on their level of risk to self. Where a patient presented a high risk of harm to self or others, they were placed on one to one observations conducted by a registered mental health nurse. Staff told us and we saw in patient notes that these observations were not always maintained by a suitably trained professional and this presented a risk to patient safety.

Senior clinicians/managers within the RAID team were involved in wider trust meetings. This allowed them to address critical incidents and other adverse events and to coordinate service planning, high-risk scenario planning and reviewing clinical and organisational safety.

The hospital did not have access to a ‘high risk’ room suitable for conducting mental health assessments. This meant patients attending the ED because of a mental health crisis, such as self-harm or a suicide attempt, were unable to be assessed and reviewed in a space which was free from objects or fittings that the patient could use to harm themselves. The lack of a mental health assessment room also meant patients at risk of self-harm or suicide were unable to be observed appropriately. Staff told us they used certain cubicles within the emergency department to mitigate this risk and kept curtains open to allow them to observe patients at risk. However, this presented a risk to patient dignity and privacy. This had been highlighted as an issue several times within the trust’s risk register and had resulted in the trust not receiving accreditation from the Psychiatric Liaison Accreditation Network.

The clinical decision unit had two ‘anti-ligature’ rooms that were specifically used for patients who presented with a mental health concern. Ligature points are fixtures to which people intent on self-harm might tie something to strangle them self. These rooms had bigger windows to allow for staff observations and had anti-ligature door handles. However, we noted this room contained several potential ligature points and this presented a serious risk to patient safety. Staff told us patients were risk assessed prior to being cared for in this room and that one to one observations were used to mitigate the risk of a patient hurting themselves.

The resuscitation department delivered trauma training to senior ED nurses in line with the National Major Trauma Nursing Network Group levels 1 and 2 requirements with support from the ED clinical educator and provided specialist training in topics such as blast injuries, cardiac arrest management and teamwork, open fracture management and the management of traumatic injury in pregnancy.

**Nurse staffing**
The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in urgent and emergency care.

The overall fill rate for qualified nursing staff dropped from 87.4% in March 2018 to 75.2% in June 2018.

The staffing data for June 2018 for Queen Elizabeth hospital shows a drop of over 260 members of qualified nursing and midwifery staff. This has been queried with the trust.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018 Actual staff – WTE in month</th>
<th>June 2018 Planned staff – WTE</th>
<th>Fill Rate</th>
<th>March 2018 Actual staff – WTE in month</th>
<th>June 2018 Planned staff – WTE</th>
<th>Fill Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>275.5</td>
<td>285.6</td>
<td>96.5%</td>
<td>10.5</td>
<td>9.3</td>
<td>113.3%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>129.5</td>
<td>165.1</td>
<td>78.5%</td>
<td>122.7</td>
<td>172.0</td>
<td>71.3%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>59.8</td>
<td>76.5</td>
<td>78.1%</td>
<td>61.2</td>
<td>76.5</td>
<td>80.1%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>34.0</td>
<td>43.8</td>
<td>77.6%</td>
<td>32.2</td>
<td>43.8</td>
<td>73.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

We spoke with the ED and CDU matron about nursing vacancies during our inspection in lieu of the lack of data from the trust. The CDU had 20 whole time equivalent (WTE) staff nurse vacancies with evidence of successful on-going recruitment drives and support from the senior divisional team. Nurse recruitment in the ED had a successful track record and the divisional team had recruited an additional 50 qualified nurses following a review of the nursing establishment needed to safely operate the department. At the time of our inspection the ED was short of three WTE staff nurses and four WTE senior staff nurses and had interviews scheduled. The department had successfully recruited 10 senior HCAs.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors turnover for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 1.8%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From April 2017 to March 2018, the trust reported a sickness rate of 4.6% for qualified nursing staff in urgent and emergency care. This is above the trust targets of 3.6% for Queen Elizabeth Hospital.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 4.2%
- Birmingham Heartlands Hospital: 4.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From April 2017 to March 2018 the trust reported 3,075 shifts were filled by agency staff, 16,830
by bank staff and 11,578 shifts were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>851</td>
<td>12,033</td>
<td>7,850</td>
</tr>
<tr>
<td>Other sites</td>
<td>2,224</td>
<td>4,797</td>
<td>3,728</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

Senior nurses maintained a staff nurse to patient ratio of 1:4 and an HCA to patient ratio of 1:6 in the ED majors area and a nurse to patient ratio of 1:2 in the resuscitation unit.

Military nurses worked regularly in the ED and were supernumerary to the established NHS team. The nurses were experienced specialists in urgent and emergency care and several members of this team were emergency nurse practitioners (ENPs).

ED and CDU nurses shared similar skill sets and senior nurses arranged to spread planned staffing across the departments in advance of weekends where full rotas fell short.

The CDU matron was working with the older people’s assessment and liaison team (OPAL) service to establish a benchmark establishment level for their workforce. This would enable the team to identify optimum staffing levels at key times and address times of high demand where staffing levels could be increased. This was demonstrative of the proactive approach to workforce reviews carried out continually by CDU and ED teams.

Two registered nurses and one emergency care technician (ECT) staffed the AMC 24-hours, seven days a week. A registered nurse and HCA staff the EOU on the same basis.

**Medical staffing**

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in urgent and emergency care.

The overall fill rate rose from 82.6% in March 2018 to 90.8% in June 2018. However, the staffing data for June 2018 for Queen Elizabeth hospital shows a rise of around 530 members of medical staff. This has been queried with the trust.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>70.9</td>
<td>72.5</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>57.2</td>
<td>81.4</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>8.0</td>
<td>11.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
From April 2017 to March 2018, the trust reported a turnover rate of 13.1% for medical staff in urgent and emergency care.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors turnover for trends and spikes and benchmarks the activity. The hospital had a turnover rate of 6.7%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From April 2017 to March 2018, the trust reported a sickness rate of 1.0% for medical staff in urgent and emergency care. This is below the trust targets of 3.6% for Queen Elizabeth Hospital.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 0.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From April 2017 to March 2018 the trust reported that 6,179 shifts were filled by locum medical staff, 4,194 by bank medical staff and that 861 were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Locum</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>1,137</td>
<td>1,564</td>
<td>99</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>2,632</td>
<td>1,135</td>
<td>432</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>2,222</td>
<td>1,384</td>
<td>328</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>188</td>
<td>111</td>
<td>2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In May 2018, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average.

### Staffing skill mix for the 102 whole time equivalent staff working in urgent and emergency care at University Hospitals Birmingham NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>24%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (Str) 1-6
* Junior = Foundation Year 1-2
The ED did not meet minimum Royal College of Emergency Medicine (RCEM) recommendations for consultant cover. The service required 28 whole time equivalent (WTE) consultants for its size and status as a major trauma centre. At the time of our inspection there were 13.3 WTE consultants in post against a budgeted establishment of 16.5 WTE and no on-site cover between 12am and 8am. However, updated RCEM recommendations had only been published in September 2018, a few weeks before our inspection. In addition, a policy was in place for a consultant to be called in in the event of a major trauma call overnight. This policy was in line not only with RCEM guidance, but also applicable National Institute for Health and Care Excellence (NICE) guidance and the NHS standard contract for a major trauma service.

Two new consultants were due to take up post from January 2019 and funding had been agreed for a third consultant although this would not increase cover to the RCEM standard for a major trauma centre. The senior team had implemented strategies to mitigate this risk. For example, a policy was in place to call in a consultant overnight in the event of a major trauma call. In addition, a consultant had carried out an audit of the impact on major trauma outcomes of not having on-site consultant cover 24-hours and found no identifiable contribution to reduced patient survival.

Between eight and 16 middle-grade and junior doctors were on shift in the main ED at any one time, including at weekends.

Four deanery trainees and four trust junior ‘standard’ doctors formed the registrar team. There was one vacancy on this team and a pool of locum doctors formed a bank to cover it.

Four senior ED nurses had progressed to trainee advanced clinical practitioners (ACPs) and were managed by medical consultants to provide more specialist care. Once qualified the ACPs would be counted in the medical workforce, which would significantly improve cover in the majors and in trauma.

A consultant and a registrar supervised each of the six key areas of the CDU from 8am to 5pm. Each team carried out a daily post-take ward round and reported into the lead consultant of the day as part of an established system to ensure continuous medical supervision of patients. A post-take ward round is a strategy used to review patients for whom a consultant has made a decision to admit. Overnight a team of registrars were based in the unit with support from an on-call consultant. Specialist registrars in cardiology, liver medicine, hepatology, renal medicine and oncology were available overnight to support the CDU team.

Overnight and at weekends in the CDU, one specialist registrar, two senior house officers and two FY1s provided cover. A second registrar worked between the wards and the CDU.

**Records**

Staff in the ED used two electronic systems to document care and monitor patient wait times. One system was used only in the ED and staff used this to track patients from their time of arrival in each stream, such as presenting themselves at reception or being transported by paramedics. Staff used the trust-wide prescribing information and communication (PICS) system to complete medical notes and observation charts. PICS provided staff with access to medical history, clinical letters and diagnostic and monitoring results, such as for non-invasive ventilation.

The two systems were separate and staff said this could be frustrating and cause delays whilst they searched for information. The IT team was working with senior divisional staff to explore the possibility of future integration between the systems. A IT support lead was working with the
matron to establish a free text field in PICS to enabled medics to type notes without being restricted by pre-selected information and definitions.

Staff used computers on wheels in each clinical area to update patient records in real time during reviews and handovers.

Staff carried out a monthly documentation audit in the ED using a sample of 20 patient records per month. Audits for July 2018 to September 2018 demonstrated consistently good standards of risk assessments for skin integrity and falls with a need for improvements in the completion of hourly observations, use of SEWS and completion of personal property forms. Although audit outcomes indicated areas for improvement it was not evident action plans were in place.

In five seven of notes we reviewed in the CDU, staff had completed and updated appropriate risk assessments for six patients. They had not completed a skin integrity assessment or a falls risk assessment for a patient recently admitted from a care home who was at high risk of both issues. We spoke with the nurse in charge about this who began an investigation immediately. This was an anomaly in our checks and the general standard of notes was high and in line with General Medical Council (GMC) and Nursing and Midwifery Council (NMC) guidance. In all examples staff had documented allergies, vital signs, the safety checklist and an initial pain score. Staff had signed and dated all entries, which were legible and detailed. The time to consultant review was identifiable in each record.

We reviewed three sets of patients notes in the AMC. In each case staff had completed relevant risk assessments, allergies, medical history and care plans. One patient had received an echocardiogram (ECG) result but there was no evidence a doctor had labelled or signed this.

Where staff had identified mental health concerns during initial triage, they had completed a full mental health risk assessment. Notes indicated how long the patient had waited from arriving in the ED to being assessed in triage and then by RAID. Staff documented whether the personal had had a known mental health crisis in the past and detailed history where applicable. Staff also noted if the patient had a permanent home and any known details of their relationships. However, in one patient’s record the family contact details were scribbled on a scrap of paper and it was unclear which number belonged to which family member or what the relationship was.

CDU staff had access to the relevant information to support the mental health needs of patients. However, CDU staff, including the mental health liaison team, did not have access to the clinical notes and risk assessments held by the RAID team. This was due to the two teams using different electronic recording systems. This presented a risk as ward staff were unable to access risk assessments and clinical notes completed by the RAID team. The RAID team did not have easy access to information regarding the legal status of patients they supported and were unable to identify how many patients within the hospital were currently detained under the Mental Health Act.

**Medicines**

The admission pathway to CDU meant patients were usually seen by an ED doctor first, who prescribed medicine. However, pressures on the service meant these were not always administered to patients before they were transferred to the CDU. Staff in this unit told us this caused delays to treatment as it meant they had to investigate where the medicines were and why they had not been given.
Controlled drugs (CDs) were stored securely with controlled staff access and daily documented safety checks in line with trust and national guidance, which included a daily record of stock checks by two nurses. We looked at the records for the previous two months and found consistent standards with no gaps. Staff stored intravenous (IV) fluids securely and safely in a locked room with restricted access and fluids elevated off the floor.

We observed three instances of nurses administering medicine. In each case staff following trust processes including correct infection control precautions and checks of patient identity and allergy status.

Lead pharmacists for ED and CDU were in post and pharmacy technicians provided support in the event of missed doses and expired medicines. This was part of a wider programme to reduce errors and ensure good stock control processes and provided additional safety and quality assurance.

Staff are required to carry out daily temperature checks on fridges used to store medicines. This is to ensure medicines are stored within the safe temperature limits set by the manufacturers, which means they remain stable and effective. We looked at the documented temperature records for the medicines fridge in the resuscitation unit and found highly inconsistent practice, with 51% of checks missing between August 2018 and October 2018. This meant that out of 76 daily checks staff had not completed 42 of them. This fridge was unlocked throughout our inspection although a notice was in place instructing staff to lock it after use. We asked four nurses about this, each of whom had a different understanding of the process. One nurse said the lock was broken and awaiting repair but the other three nurses said they did not think that was the case and that it was always unlocked for various reasons.

The chief pharmacist and patient safety and non-medical prescriber (NMP) pharmacist led a quarterly patient safety group CD audit to identify levels of safety compliance against the trust 85% standard, including compliance with Misuse of Drugs Act. The CDU achieved the minimum standard in both March 2018 and July 2018 with an average compliance of 91%. The ED achieved 85% in this period, reflecting one period of compliance and one period of non-compliance.

The pharmacy and medicines safety teams carried out monthly audits of medicines management in each ward or clinic area to establish standards against 42 safety and quality criteria. In September 2018 and October 2018 compliance in the ED was 94% and the CDU achieved 82% against a trust minimum standard of 90%.

From April 2018 to October 2018 staff reported 85 incidents relating to medicines management, which reflected 2% of the total incidents reported.

Medicines trolleys in the CDU were very congested and there were medicines labelled with patient’s details who were no longer in the department. This meant there was a need for more robust stock control systems.

Staff did not always act when the medicines fridge recorded temperatures that exceeded the maximum safe limit established by manufacturers. Staff in CDU had documented several occasions when this temperature had been exceeded although there was no documented resolution.

Staff did not appropriately segregate potassium infusions.
From April 2018 to October 2018 staff reported 1625 incidents relating to medicines management, which reflected 44% of the total incidents reported, of which 4% related to non-compliance with clinical policies or procedures.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust reported no incidents classified as a never event for urgent and emergency care occurring from August 2017 to July 2018.

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust reported one incident classified as a never event for urgent and emergency care occurring from August 2017 to March 2018. This related to a misplaced naso- or oro-gastric tubes and occurred in November 2017 at Birmingham Heartlands Hospital.

*(Source: NHS Improvement - STEIS)*

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England occurring between August 2017 and July 2018.

The breakdown by type of incident reported were:
- Diagnostic incident including delay (including failure to act on test results): six (33.3% of total incidents)
• Treatment delay: five (27.8% of total incidents)
• Slips/trips/falls: five (27.8% of total incidents)
• Surgical/invasive procedure incident: one (5.6% of total incidents)
• Sub-optimal care of the deteriorating patient: one (5.6% of total incidents)

Site specific information can be found below:
• Queen Elizabeth Hospital (August 2017 to July 2018): 12 incidents

(Source: NHS Improvement - STEIS)

Between April 2018 and October 2018 staff reported 3678 incidents in ED, the CDU, the AMC and the EOU. Of these, 91% were recorded as low or minor harm and 9% resulted in no harm or were classed as a near miss. In most appropriate cases staff documented an outcome, action point or learning from each incident.

There was evidence of learning from avoidable incidents. For example, staff had discharged a child home despite the presentation of significant injuries that raised suspicions of abuse. In addition, the discharging member of staff had contacted the incorrect community safeguarding team. Following the incident senior staff and the safeguarding team worked with clinical teams through one-to-one briefings and additional training to improve their understanding of referral pathways, including in urgent safeguarding situations.

Staff had acted on learning from a serious incident in the ED that involved a patient falling and sustaining a head injury and a fractured neck of femur. For example, staff completed a full falls risk assessment for each patient on attendance at the ED as part of their initial safety checklist. At this stage they implemented one-to-one supervision of the patient if they were considered to be at heightened risk of falls.

Although staff demonstrated a good understanding of learning from incident investigations, they did not always have ready access to documentation such as the root cause analysis or investigation. For example, the ED matron said they did not have access to this information and would need to request access to it. This meant staff could experience delays in obtaining important information about the outcomes of incidents that could help them to deliver care.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care as all incidents were reported under the core service ‘Other’.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?
Evidence-based care and treatment

Staff delivered care and treatment in line with national guidance, including from the National Institute of Health and Care Excellence (NICE). For example, staff carried out a computed tomography (CT) scan for each trauma patient, which is 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.

Clinical teams were research-active and promoted research with trainee doctors and other professionals in partnership with the adjacent university. Research was designed to achieve a range of outcomes including the exploration of patient experience, improvement of clinical outcomes and benchmarking of standards against national guidance. Research teams had focused on patients in the clinical decision unit (CDU) as a key strategy to assess the feasibility of new work and practice. Recent research projects in the department included routinely testing patients for HIV, assessing the impact of a point of care test for influenza and assessing the beds for compliance with NICE clinical guidance 174 in relation to passive leg raises by physiotherapists.

A research physiotherapist was based in the CDU one day per week and encouraged research within the team that would contribute to improving evidence-based care, such as the treatment of patients with emphysema.

Senior allied health professionals monitored NHS Improvement patient safety alerts and made these available to all members of the team involved in delivering care.

The trust had a standard that all policies should be reviewed annually or whenever the national or international guidance on which they were based changed. Divisional governance teams monitored compliance with this in monthly performance meetings.

Staff teams were demonstrably focused on developing an evidence base for their work and initiatives and used structured audits and research to accomplish this. For example, a team had carried out a PDSA (‘plan, do, study, act’) cycle to identify the suitability of the emergency observation unit (EOU) to deliver the frail elderly pathway. Stage one of the exploration identified that the EOU was not the most suitable location and the team were reviewing the use of the pathway before carrying out the next stage of the research cycle.

A consultant audit lead was in post in the main ED and led a rolling audit programme to improve standards of care, practice and patient outcomes.

Staff screened for sepsis and coordinated treatment in line with national UK Sepsis Trust Sepsis Six and Red Flag Sepsis guidance.

Staff had access to local and national clinical guidelines on the trust intranet, with local back-up.
copies maintained in the event the trust systems failed. We reviewed a sample of three clinical
guidelines for diabetic ketoacidosis (DKA), deep vein thrombosis and spinal cord compression.
Each policy was up to date, based on appropriate national and professional body guidelines and
had documented review dates.

The CDU team had carried out a pilot ‘perfect week’ in which they temporarily changed working
practices and resources to assess the impact on patient care, experience and outcomes. This
was a whole-team, multidisciplinary effort that demonstrated the department’s significant focus on
improving performance and benchmarking care. During the pilot the team increased consultant
working hours, actively monitored compliance with NICE guidelines and implemented
enhancements such as point of care diagnostic testing and increased pharmacy cover. An audit
of ED activity during the perfect week showed the change in CDU services resulted in a 25%
drop in ED activity, which significantly improved the team’s ability to meet demand.

The matron used the week to carry out a workforce review, which resulted in recruitment for an
additional 10 senior staff nurses and recruitment for emergency care technicians. The pilot
helped to explore how the CDU could better support the ED during times of extreme demand,
such as more proactive admission of patients waiting in the ED. The perfect week project
identified a need for a workforce review of the acute medical clinic (AMC) to increase staffing,
which was underway at the time of our inspection.

A research and audit team had carried out an observation of blood transfusion standards and
practices in the CDU in response to audit results that demonstrated 28% compliance with trust
and national standards, which was significantly lower than the trust target of 90%. The research
team worked with nurses to improve training and knowledge through a five-cycle programme and
the provision of easy-access guidance on blood transfusion processes. This resulted in a 49%
compliance improvement, from 47% to 96%, in the 18 months of the programme.

Dedicated nurses led the triage service and had completed training and competencies in the use
of the Manchester triage system to ensure 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. When a child
presented the triage, nurse carried out the additional safety net check on the electronic records
system.

Allied health professionals carried out an on-going programme of audits to benchmark care and
patient outcomes and to drive improvements in practice. In one example, physiotherapists
audited the referrals to the service from the CDU from January 2018 to April 2018. Of the 187
patients referred, the physiotherapy team saw 59%. Of the patients not seen, 47% was because
they were low priority and demands on the service from high priority patients meant therapists
could not attend to others. The team did not see other patients for reasons such as being
transferred to a ward before the team could reach them or, in 13% of cases, because the older
person’s assessment and liaison (OPAL) team reviewed them. The audit highlighted a missed
opportunity for patients admitted to the CDU following a fall. CDU staff did not refer these patients
to physiotherapy or to OPAL as they were outside of the pathway criteria. The team used the
audit results to ensure falls patients were not missed for therapeutic intervention.

**Nutrition and hydration**
In the CQC Emergency Department Survey, the trust scored 7.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

Patients in the CDU said they were happy with the standard of food and said staff always provided snacks between mealtimes on request. One patient said they had woken in the middle of the night and were pleased staff had brought them a sandwich when asked.

Hot drinks, water, juice and snacks were available on request in the ED, EOU, AMC and CDU, including for relatives who were in the department for long periods of time.

Speed and language therapists (SaLT) and dieticians had carried out a project in CDU that identified a third of patients were malnourished on admission and staff referred 18 patients to the AHP teams when 52 were eligible for this. The project team identified a need for significant improvement in communication with doctors and understanding of referral criteria as well as a broad increase in understanding of the NHS Improvement nutrition collaborative to ensure staff identified patients who were admitted from the local area who they could help with interventions. As part of the project the team monitored mealtimes to identify how ward teams identified and delivered special meal and assistance requirements.

As a result of the project, dieticians increased the scope of their care to include a review of all patients admitted to the CDU. This was an improvement from previous practice and reduced the risk of missing the signs of malnutrition. This contributed to care planning to avoid unnecessary admission and promote individualised discharge planning.

Dietician-led screening, using the malnutrition universal scoring tool (MUST), was part of a new academic partnership that contributing to masters-level study amongst dieticians and expanded the ability of clinical teams to monitor patients for malnutrition.

SaLT therapists and dieticians supported mealtimes on the CDU to ensure patients were being properly supported. Physiotherapists and occupational therapists supported mealtimes to ensure changes were implemented immediately, such as artificial feeding. This was part of a wider programme to ensure nutrition was evidence-based and individualised and helped AHPs to identify patients early and track them through the hospital using the nutritional management element of PICS.

**Pain relief**

In the CQC Emergency Department Survey, the trust scored 5.0 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

A consultant-led pain audit of children in 2018 found only 10% had a documented pain score within 15 minutes, as defined by the Royal College of Emergency Medicine. The consultant worked with the wider ED team to identify shortcomings and implement an action plan. Results from a fractured neck of femur audit identified a need for significant improvement in the time to analgesia.

During our inspection, staff completed pain scores for each patient and trust policy required them to update these as part of hourly observations. Documentation audits from July 2018 to September 2018 demonstrated staff consistently recorded these. In all areas we observed staff
administered pain relief in a timely manner and checked regularly with patients about their level of pain. Emergency nurse practitioners (ENPs) were nurse prescribers and administered pain relief to patients who presented with minor injuries.

We reviewed the initial documentation of 33 patients who were triaged in the ED on one day of our inspection and found staff had completed pain scores and offered pain relief in each case.

Nurses with assessed competencies used patient group directions (PGDs) to administer analgesia at the point of triage. PGDs are… This meant patients had rapid access to pain relief on arrival delivered by skilled staff.

A patient in the EOU said they had asked staff for pain relief several times but they had not received this. However, this was an exception and all of the 13 other patients we spoke with said staff had provided timely pain relief.

**Patient outcomes**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, the Queen Elizabeth Hospital emergency department failed to meet any of the national standards of 100%.

The department was in the upper UK quartile for two standards:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 48.0%; UK: 26%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 89.8%; UK: 77%.

The department was not in the lower UK quartile (the worst proportion) for any of the standards.

The department’s results for the remaining five standards were all within the middle 50% of results.

- Standard 1a (fundamental): O2 should be given on arrival to maintain sat’s 94-98%. This department: 18.0%; UK: 19%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 21.0%; UK: 25%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 33.3%; UK: 19%.
  - Standard 5b (fundamental): within 4 hours (moderate). This department: 40.5%; UK: 28%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
Children 2-5 years: 20mg prednisolone for 3 days

This department: 40.4%; UK: 52%.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Consultant sign-off audit, Queen Elizabeth Hospital emergency department failed to meet any of the national standards of 100%.

The department’s results for all the reported standards were all within the middle 50% of results.

- **Standard 1 (developmental):** Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 15%; UK: 11%.

- **Standard 3 (fundamental):** Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 14%; UK: 12%.

- **Standard 4 (developmental):** Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 14%; UK: 10%.

Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age was not reported by the trust.

(Source: Royal College of Emergency Medicine)

The consultant audit lead found overall consultant sign-off to be 21% in 2018, which demonstrated a need for significant improvement.

In the 2016/17 Severe sepsis and septic shock audit, Queen Elizabeth Hospital emergency department failed to meet any of the national standards of 100%.

The department was in the lower UK quartile for one standard:

- **Standard 1:** Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 45.6%; UK: 69.1%.

The department’s results for the remaining seven standards were all within the middle 50% of results:

- **Standard 2:** Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 59.1%; UK: 64.6%.

- **Standard 3:** O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 33.3%; UK: 30.4%.

- **Standard 4:** Serum lactate measured within one hour of arrival. This department: 67.6%; UK: 60.0%.

- **Standard 5:** Blood cultures obtained within one hour of arrival. This department: 35.8%; UK: 44.9%.

- **Standard 6:** Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one
hour of arrival. This department: 56.5%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 44.6%; UK: 44.4%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 7.5%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

From August 2017 to July 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average.

Unplanned re-attendance rate within seven days - University Hospitals Birmingham NHS Foundation Trust

Please note: This includes attendances for April to June 2018 which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.

(Source: NHS Digital - A&E quality indicators)

The specialist respiratory physiotherapy team led an annual acute NIV audit with respiratory consultants to assess the success rate of the treatment initiated in the ED. In the most recent audit in 2018, the audit found an 80% success rate. This was significantly higher than the national average of 66% success rate in the most recent BTS adult NIV audit. The team planned to run a pilot of the national audit in preparation for this in 2019, which would enable them to further benchmark standards of care nationally.

A specialist HIV consultant had led a project in CDU in January 2018 to implement routine HIV testing of all patients on an opt-out basis. There were no comparable initiatives in the trust, which meant potential unknown HIV infections could be missed. The pilot scheme results had confirmed regional incidence rates of two HIV positive results per 1000 people and highlighted the benefits to patient outcomes of early testing and treatment. As a result, other specialties in the hospital implemented more proactive HIV testing, including critical care and trauma and orthopaedics.

The falls team devised a ‘back to the floor’ audit tool to align with the National Audit of Inpatient Falls and NICE guidance. The team carried out audits at a frequency based on level of risk in each division, based on incident reporting trends. The most recent audit results related to August 2018, which showed overall hospital compliance over the target of 95% was achieved in eight out
of 15 aspects of falls prevention methodology. Overall the CDU demonstrated compliance in seven of the 12 measures applicable at the time of the audit, with overall compliance at 68%. This was an average and reflected 0% compliance in measures relating to lying and standing blood pressure and the use of assessment tools for patients with delirium or confusion and 100% compliance in even measures. The unit performed variably for remaining measures. For example, in 50% of cases the use of bed rails was appropriate and in 60% of cases staff had reviewed medicines in relation to falls risk. As part of a broader programme of improving outcomes for patients at risk of falls, AHPs reviewed all falls patients and all patients who suffered a fractured neck of femur 24-hours, seven days a week.

Physiotherapists who led the MSK service in ED minors audited demands on the service during March 2018. In this month the team saw 1590 patients, with an average of 12 patients per shift, 95% of whom were seen and discharged by the physiotherapist within three hours and 35 minutes. The audit identified an unplanned reattendance rate of less than 1% and the use of imaging services by physiotherapists was conservative and clinically appropriate. Physiotherapists could refer onwards to 14 different services and specialist clinics, such as the shoulder clinic and neurology clinic, which significantly reduced pressure on ED services to accept minor injuries.

Competent staff

From April 2017 to March 2018, 77.2% of staff within urgent and emergency care at the trust received an appraisal. This is below both the trust target for Queen Elizabeth Hospital of 90% and the target for other sites of 85%.

Both medical and dental staff and support to scientific, therapeutic & technical staff had 100% appraisal rates.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>47</td>
<td>47</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>120</td>
<td>157</td>
<td>76.4%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>64</td>
<td>84</td>
<td>76.2%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>116</td>
<td>153</td>
<td>75.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>215</td>
<td>288</td>
<td>74.7%</td>
</tr>
</tbody>
</table>

From April 2017 to March 2018, 75.7% of required staff across the Queen Elizabeth Hospital urgent and emergency care services received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>15</td>
<td>15</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>65</td>
<td>87</td>
<td>74.7%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>91</td>
<td>124</td>
<td>73.4%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
</tr>
</tbody>
</table>

Both medical and dental staff and support to scientific, therapeutic & technical staff had 100% appraisal rates. No other staffing groups met the target appraisal rate.

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)
The OPAL team delivered a presentation to new junior doctors in the ED and CDU to help them identify patients who were appropriate for referral and when to contact the team.

Clinical Educators (CEs) were dedicated to the ED and worked with departmental staff to increase education and training provision. CEs focused on staff development and two staff nurses had protected time weekly to work on training opportunities and engage colleagues with these. CEs provided highly visible, front-line support for staff when they need it. For example, they supported nurses to deliver care for patients with complex needs and provided opportunistic practical training and instruction. CEs had worked with the ED and CDU matrons to secure a system of protected time for training opportunities to nurses and HCAs. This meant staff had access to continual training despite the pressures on the department.

Two CEs were assigned to the CDU and had developed simulation training for HCAs and nurses to support them in delivering care to acutely unwell patients. They delivered simulation training as whole-team events that included structured scenarios and a formal debrief afterwards. The education team had identified doctors who were passionate about delivering training to the nursing team and developed training sessions that included doctor-led delivery. The ED CE had developed multidisciplinary simulation training that took place weekly and was based on case studies they developed from working in the department.

CEs recognised the benefits of multidisciplinary teaching and learning opportunities and opportunistically developed these between staff groups. The team had introduced training modules based on Royal College of Nursing guidelines and best practice. For example, the team had organised a rapid sequence intubation (RSI) training day for ED nurses and critical care nurses to attend jointly. The team involved military doctors and military medical students in training days and military doctors delivered training sessions in triage, life support and trauma.

Specialist respiratory physiotherapists provided education and learning sessions to staff in identifying sepsis in patients who presented with an acute respiratory or NIV need as part of a programme to improve care for acutely unwell patients.

OTs, the falls lead nurse and CEs worked together on the CDU to improve staff knowledge and understanding of the appropriate use of walking sticks. This was a project to address the needs of frail patients admitted out of hours who had mobility needs. The training meant nurses were able to carry out assessments for walking sticks or frames and provide these immediately.

The SaLT team developed a training programme for ED nurses that enabled them to carry out swallowing assessments. This meant patients would benefit from additional assessments when the SaLT team was unavailable, such as overnight.

Members of the reception team in ED were able to take part in a rotational programme with colleagues who operated the emergency 999 desk. Staff told us this was a good opportunity to improve their skills and gain experience in a different role.

CEs delivered training to staff in the ED and CDU to help them de-escalate situations and provide dedicated care for patients experiencing issues that resulted in aggression and extreme frustration.

The CDU team recruited band two HCAs with the intention of offering onward structured development pathways to emergency care technicians. This was an attractive option to new recruits and the department experienced successful recruitment drives as a result.

Band two HCAs had access to a development programme after one year of satisfactory performance. This led to more senior roles and an associate nurse practitioner pathway. Three trainees were in post at the time of our inspection, each of whom had progressed internally.
Junior doctors had access to weekly protected time for departmental teaching and weekly off-site deanery teaching. All the doctors we spoke with said they considered the standard of teaching to be “excellent” and this was a key deciding factor in their choice of work location.

Two senior nurses were enrolled on a masters-level advanced care practitioner (ACP) course that would result in their inclusion in the middle-grade doctor rota following successful completion. Two fully qualified ACPs were due to start in the department in November 2018 to supplement the established medical team. This programme reflected the department’s focus on advanced staff training and development to improve specialist care and implement innovative solutions to staffing challenges.

Staff nurses and senior staff nurses adopted link roles in specialist areas or subjects, such as dementia, mental health or resuscitation. This enabled each individual to focus in detail on a topic of interest to them and to work with the site leads to undertake more advanced training, which they used to support colleagues in their own department.

The emergency nurse practitioner (ENP) team delivered monthly teaching sessions to the ED team to help develop nursing skills in minor injury and illness treatment.

Nursing associates in the CDU had the opportunity to undertake developmental training that would result in their promotion to emergency care technician, which would include phlebotomy duties.

The mental health liaison team had carried out a substantial training programme for nurses in the CDU. From February 2018 to April 2018 the team carried out 114 instances of training across 15 specialist subjects including supporting distressed relatives and clinical subjects such as organic brain disease and alcohol-related brain injury.

ED CEs created a cardiac arrest scribe tool following an audit of cardiac arrest documentation, which helped staff to document care and treatment more usefully and consistently. Educators evaluated study sessions to facilitate more tailored opportunities for staff in the future, such as when staff highlighted areas that could further improve their clinical practice.

Staff had the skills, knowledge and experience to identify and manage issues arising from patients’ mental health conditions. CDU staff used the expertise of the mental health support teams within the hospital to manage patients’ mental health needs effectively. However, one staff member we spoke with told us they did not feel they had received enough training around supporting patients’ mental health needs.

Mental health support teams had access to appropriate specialist support both within and outside of the hospital and staff completed a competency framework in caring for people with mental health needs when they joined the service.

The RAID team had a specialist older adult psychiatrist within the team and ward staff used this expertise in supporting patients with dementia. Staff had access to dementia training within the hospital. We saw evidence of detailed mental health and cognitive assessments being used to assess patients’ needs and clear plans in place to best support patients.

**Multidisciplinary working**

Multidisciplinary working was demonstrably embedded in all areas of the service. There was consistent evidence of this during board rounds, ward rounds and safety huddles.

Physiotherapists and OTs were assigned to cover trauma, with therapists working on a rotational basis to ensure they could respond to an increase in demand.
A consultant geriatrician, specialist registrars, FY doctors, nurses and AHPs provided the OPAL service. This service was based in CDU from 7.30am to 8pm seven days a week. The team prioritised sourcing the most appropriate community placement for vulnerable patients and those with complex social, physical and mental health needs.

A team of AHPs delivered specialist care in the ED, the CDU and as part of the OPAL team. The team included OTs, physiotherapists, SaLT and dietetics. The team provided care to patients with specialist needs including in respiratory medicine for those receiving NIV and specialists in cardiology, stroke and HIV. 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.

A full time and a part time nurse provided the mental health liaison team and supported the RAID team. They provided input five days per week and offered debriefing and twice-weekly reflective practice sessions for staff to attend following challenging incidents. Reflective practice is the ability to reflect on one’s actions to engage in a process of continuous learning. The team also signposted staff and patients to additional external support networks where appropriate.

Paramedics and the OPAL team worked together to assess patients at risk of falls or other risks associated with frailty and ensured they were assessed in the most appropriate location. The OPAL team worked with the community rapid response team to coordinate the care of patients who became acutely unwell at home or in social care accommodation, such as with acute chest infections or urinary tract infections. The OPAL team had secured the installation of software that would enable them to access the medical care records of patients cared for in the community. This would significantly improve coordination between the hospital team, GPs and the rapid response team.

A mental health liaison team was based in the CDU and provided support to staff in mental health assessments and needs reviews. Specialist nurses provided scheduled, ad-hoc and on-demand training and guidance for CDU staff when delivering care to patients with complex needs and helped to improve their understanding of the Mental Capacity Act 2005 and the Mental Health Act YEAR. The team was able to lead interventions for patients and worked with clinicians to identify the most appropriate course of action for them.

Two mental health nurses from the RAID team filled liaison advisory roles for the CDU team. They undertook reviews of patients admitted with mental health needs and worked with the OPAL and community teams to coordinate care for patients with complex needs. The nurses provided debrief sessions for CDU staff affected by difficult or stressful situations and ensured patient care was more consistent. The team aimed to address the outcomes of the 2017 National Confidential Enquiry into Patient Outcomes and Death (NCEPOD), which highlighted significant shortfalls in mental health provision nationally. The liaison team had identified gaps in the mental health training of newly qualified nurses and provided dedicated education opportunities alongside ad-hoc practical coaching.

The Queen Elizabeth Hospital at Home team provided community services for patients discharged from the ED or CDU and staff in the hospital made direct referrals to ensure there were no gaps in care. The community teams had access to the hospital’s ERS, which meant different teams could track patient’s care and treatment. This facilitated continual multidisciplinary working and reduced delays in staff from different teams accessing important information. This system applied to all teams except occupational therapists, who used a different community rapid response system connected with where a patient was registered with a GP. OTs based in the ED were working with
community-based colleagues to reduce instances of rejected referrals and align the system more closely with other therapies.

Specialist nurses from the stroke ward provided colleagues in the CDU with on-demand support and carried out screening for patients on admission.

The ED matron had worked with colleagues at another NHS trust to introduce action cards for shift coordinators. This helped senior nurses to structure the shifts and ensure important tasks were led by the most appropriate people or team. This project further established the shift system of an overall senior nurse in charge with five nurse coordinators in each section of the ED, which demonstrably worked as an effective multidisciplinary system.

ECTs in the AMC were trained to carry out procedures such as phlebotomy, electrocardiograms, cannulation and catheter care. This helped to improve the timeliness of care and released nurses to deliver more advance interventions. HCAs worked across teams and services to provide support on-demand. For example, HCAs worked in the minors stream and carried out procedures such as cannulation and plastering.

Clinical nurse specialists (CNSs) were in post for multiple specialties, including liver medicine, diabetes, safeguarding and inpatient general medicine. This team facilitated timely transfers to inpatient wards through effective multidisciplinary working. We observed this in practice with the CNS for general medicine, who proactively visited the CDU periodically to identify patients appropriate for admission with input from the wider clinical team.

Multidisciplinary teams worked together to plan the care of patients with mental health needs awaiting beds in specialist hospitals or services. In the CDU, the mental health liaison team worked with the site team and used a daily report to identify patients awaiting a psychiatric bed placement and whether they were medically fit or unfit for discharge. The system enabled the mental health and site teams to address patients with the greatest risk and prioritise action to improve their outcomes.

A hyper-acute stroke team was based on site until 7pm daily and we saw good examples of efficient working between this team and the ED team during a trauma call. A CT scanner was based next door to ED and provided staff with rapid access in patient emergencies. Such established relationships contributed to patient outcomes in emergency and trauma situations.

Seven-day services

AHP services had expanded to meet patient demand. This included an extension of the MSK service to cover six days per week from 10am to 6pm and 24-hour, seven-day availability of specialist respiratory physiotherapy.

The OPAL service operated seven days per week. However, at weekends the service was led by one physiotherapist and one therapy assistant, which staff said significantly reduced the ability of the team to meet patient’s needs in both ED and CDU.

The thrombolysis service was available 24-hours, seven days a week and a stroke nurse provided a first responder service from 8am to 12am to patients in the ED. The on-call medical registrar worked with the ED medical team to provide this service from 12am to 8am. The thrombectomy service was available from Monday to Friday and the team demonstrated the ability to provide emergency care outside of these hours as part of their plans to develop the service. For example, the whole team attended a patient during a public holiday in January 2018 to carry out an emergency procedure.
The AMC operated 24-hours, seven days a week with consultant-led care during the day. Overnight the acute medical registrar provided cover with support from medical FY1s.

GP cover in the emergency observation unit was provided Monday to Friday from 9am to 10pm. GPs provided additional weekend cover if they had capacity and at all other times a junior doctor led care in the unit.

Consultant cover in the ED was seven days a week from 8am to 12am with cover outside of these times provided remotely by phone.

ENPs and GPs led the minors service in ED from 7.30am to 12am seven days a week, with additional cover provided at weekends. This team were carrying out a workforce review with the aim of increasing ENP cover at weekends.

The pharmacy service was due to expand to provide 24-hour on-site cover for the ED and CDU, which would extend the service from the on-call overnight provision in place at the time of our inspection. This followed a successful trial on the CDU of 24-hour on-site pharmacist cover, which resulted in a demonstrable reduction in missed doses.

Physiotherapists were available 24-hours, seven days a week. Overnight four physiotherapists were on-call; two for respiratory emergencies and two for trauma. A physiotherapist in the minor injuries clinic was available seven days a week.

Health Promotion

Staff prepared health promotion information for display on the digital information screen in the main ED waiting area. This reflected current trends in health and known local risks, such as measles awareness and signposting to the bowel cancer screening programme. Public Health England posters were displayed to advise patients and visitors about the risks of Middle East Respiratory Disease (MERS) for those who had recently travelled in the region. Staff placed these posters in high visibility areas as part of their understanding of the specific risks faced in the local population.

Staff demonstrated awareness of health risks and trends in the local population and said that domestic violence was a significant concern. All staff knew how to signpost patients to domestic violence intervention agencies or police liaison officers. Posters were discreetly displayed in areas such as toilets to direct people to confidential support hotlines.

Although information was readily available digitally, the ED waiting room had only two printed health promotion leaflets, one for flu and one for minor injuries. Both leaflets were available only in English.

The mental health liaison team had a dedicated health promotion remit to address mental health stigma amongst staff, patients and visitors.

The hospital engaged in mental health promotion events and activities including the development of posters and boards for World Mental Health day, as well as other national initiatives such as Time to Talk. The hospital held weekly mindfulness sessions to support the wellbeing of staff and regular drug and alcohol screening for patients.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

A breakdown of compliance for mental capacity and deprivation of liberty safeguards (DoLS) training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
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</thead>
</table>


<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
</tr>
<tr>
<td></td>
<td>staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2/DoLS and mental capacity</td>
<td>136</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this training module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in surgery at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
</tr>
<tr>
<td></td>
<td>staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2/DoLS and mental capacity</td>
<td>6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

The clinical educator for mental health and the lead nurse for standards had successfully trialled a mental health care pathway booklet in the CDU. This provided structured support to the nursing and medical teams in coordinating care for patients with mental health needs. The pathway booklet enabled staff to track risk assessments, such as for suicidal intent or self-neglect and to document liaison and reviews with the RAID team. A shift handover form enabled staff to document their assessment of the patient during their shift and separate mental health and physical health care needs ready for the next shift.

The safeguarding team visited each patient with a DoLS authorisation in place as part of a system to ensure staff used the process appropriately and that it was in the best interests of the patient. This helped to support staff in a complex process and meant patients were protected from inappropriate restrictions.

Staff routinely documented discussions about do not resuscitate (DNAR) authorisations with patients or their next of kin.

Staff in all areas demonstrated detailed knowledge of the Mental Capacity Act (MCA) (2005) and DoLS, including their responsibilities under both and with individual patients. On the CDU staff had demonstrable understanding of patients who had been cared for an extended period of time.

We reviewed the clinical notes and care and treatment files for two patients who were detained under the Mental Health Act and were being cared for in the CDU. Staff were aware of the holding powers under Section 5(2) of the Mental Health Act and were supported by the mental health liaison team and other specialists to understand this for individual cases. However, in one of the patient notes we reviewed we noted that staff had made an urgent DoLS authorisation for a patient who was detained under Section 2 of the Mental Health Act. This demonstrated the staff were unclear on this legislation.

In one of the sets of notes we reviewed, a checklist had been completed to outline the patient had been read their section 132 rights under the Mental Health Act, their right to an independent mental health advocate, a tribunal and a hospital manager’s hearing. This had been completed by the RAID team. However, in the other patient’s care file we reviewed, there was no evidence of a
checklist to ensure the above documentation was correct and there was no evidence of the patient’s legal paperwork supporting their detention under the Mental Health Act.

The provider was in the process of recruiting a Mental Health Act administrator whose role would include oversight of all patients within the hospital who were detained under the Mental Health Act and scrutinising the legal documentation to support this. At the time of our inspection, the risk and compliance lead was responsible for monitoring adherence to the Mental Health Act.

Both sets of patient’s notes we reviewed showed detailed and comprehensive mental capacity assessments for individual decisions and evidence of liaison with other agencies to support these decisions. We saw evidence of the RAID team reviewing decisions that had been made by a multidisciplinary team in the best interests of the patient in a situation where a patient lacked capacity to make this decision.

The hospital did not engage in any Mental Health Act audits. There were plans in place to address this with the upcoming recruitment of the Mental Health Act administrator.

Staff referred to the mental health liaison team for support around consent to treatment for those detained under the Mental Health Act.

**Is the service caring?**

**Compassionate care**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was slightly worse than the England average from July 2017 to June 2018.

**A&E Friends and Family Test performance - University Hospitals Birmingham NHS Foundation Trust**

(Source: NHS England Friends and Family Test)

From April 2018 to September 2018 81% of patients said they would recommend the department. Courtesy and professionalism were themes amongst the feedback.
Throughout our inspection we observed examples of friendly and spontaneous interactions between staff and patients. In the clinical decision unit (CDU) a member of the transfer team recognised a patient and their relative from a previous inpatient stay and the member of staff approached them in a familiar, friendly manner. This had a demonstrably positive affect on the patient and was evidence of the genuinely kind and friendly nature of staff.

Patients and relatives we spoke with in the CDU said they felt staff had treated them “extremely well” and they felt staff took the time to make them comfortable and welcome despite the busyness of the department. One patient waiting to be seen in the CDU said, “The nurse has been extremely kind. It feels a bit like a railway waiting room with people rushing about but everyone is doing their best and they keep us updated.” One patient who had been admitted to the CDU said, “Everything is great. Care is fantastic and the staff are amazing, they listen to you and go the extra mile. They always knock on the door before they come in and take the time for a chat if they can.”

Staff delivered care in a way that ensured patients’ privacy and dignity. They used curtains around bed spaces when carrying out examinations or tests, told patients what they wanted to do and why and asked them if this was okay.

We observed staff in the emergency department (ED) provide kind and compassionate care to a patient living with a learning disability who was worried and anxious. Staff were patient and understanding and reassured the patient who was uncomfortable with the busyness and pace of the environment.

All 17 patients and nine relatives we spoke with said interaction with staff had been positive. Themes from the feedback related to kindness and compassion and the patience of staff they had met. Three patients and their relatives waiting in the ED corridor after being brought in by ambulance spoke highly of the ED team. Three patients in majors and seven patients in minors all said they were happy with their care and had not experienced any issues.

Reception staff were consistently polite and friendly to patients and relatives, including when they were frustrated with the length of wait or anxious. In the acute medical centre (AMC) the receptionist provided reassurance to a worried relative and although they could not provide a specific time when they would be seen, they told the relative how many patients were in front of them.

The ED and CDU scored consistently well in the annual patient-led assessment of the care environment (PLACE). In 2017 and 2018 both units scored the maximum 100% in the privacy and dignity measure.

We reviewed seven patient feedback forms about the mental health liaison team. All but one of the feedback forms highlighted the positive contribution of the team on patients’ well-being. Patients reported staff were kind, caring and felt they listened to them. One patient fed back they were not always treated with dignity and felt uncomfortable about the acronym used to shorten the rapid assessment interface discharge (RAID) team.

**Emotional support**

Where patients were distressed or anxious, staff offered them calm and kind reassurance. For example, one patient on the CDU experienced heightened anxiety and lay on the floor to make themselves feel better. A member of staff spoke to them reassuringly, explained why this was not safe and helped them move to a more comfortable place to rest.

Therapies teams and nurses worked with patients and their relatives to facilitate access to specialist non-profit organisations that provided psychological and emotional support following life-
changing injuries and trauma. For example, patients who experienced a trauma were often active professionals and life-limiting accidents significantly impacted their mental health.

The mental health liaison team worked with the rapid assessment interface discharge (RAID) team to coordinate emotional and crisis support of patients.

Staff were knowledgeable on the counselling and bereavement services available to patients and their relatives.

A faith and community centre and on-call chaplain was available 24-hours, seven days a week. The centre provided multi-faith space for prayer, meditation and conversations and services for bereaved people.

**Understanding and involvement of patients and those close to them**

The trust scored worse than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>2.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Overall</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

During shift handovers and safety huddles in ED, staff attended each cubicle in majors and introduced themselves to patients and explained what they were doing. During all of our observations staff were friendly, approachable and took time to make sure they understood how patients were feeling.

Staff in the CDU demonstrated awareness of each patient’s mood and how they were feeling. For example, a nurse asked a patient if they wanted them to come back later to carry out blood tests when they noticed they were very tired and low in mood. One patient said they felt staff were attentive and came to check on them regularly. Another patient said staff had told them clearly what to expect next and how long this would take. They said they were happy with the level of communication from everyone they had spoken to. This was demonstrative of the empathy staff showed in understanding each patient’s circumstances and situation.

Carers of patients spoke positively about the approach and attitude of staff. Two carers said they regularly attended the ED and CDU with patients they cared for in the community and said staff were always respectful and treated them with dignity. One carer said, “Something I’ve noticed is the nurses and doctors always speak straight to [patient]. They don’t speak over them and talk to me first. That’s a big deal for [patient] and makes them feel important.” Another carer said, “The staff here are marvellous. [Patient] can’t understand a lot but the staff keep it simple and let me know help them to communicate.”

Staff told us the reputation of the hospital in the region meant patients often bypassed their local healthcare provider and presented directly at the hospital. Staff said this most often occurred amongst patients with highly specialist needs such as liver transplant patients and they recognised this as evidence of the high standards of care they provided.
Staff routinely introduced themselves to patients and relatives with them and explained their role and what they were there to do. For example, in the AMC we saw an emergency care technician introduced themselves to a patient and tell them they wanted to take their blood pressure and temperature and asked them if they were happy to proceed.

One patient in the AMC said staff had kept them informed and about the progress of their treatment and had answered all their questions. A patient in the EOU said staff had kept them informed during their transfer from the ED and had explained why their treatment was more appropriate there. Another patient said they had been worried because doctors could not make a diagnosis. However, they said the medical team had kept them informed with tests results and next steps and felt the team had been thorough in assessing their needs.

One patient in the CDU said, “I’ve been here two weeks and different doctors keep telling me different things. Some days I’m going home and some days I’m not. I don’t mind I just wish they would talk to each other about the information.”

The mental health liaison team collected feedback from patients and relatives, which indicated high levels of satisfaction with their work and approach to specialist care. Patients said they felt the team understood them and provided a dedicated alternative to medical nurses.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

A sports medicine team had developed services and expertise to meet the needs of the large local university population, such as high numbers of sports injuries. The team included a consultant in sports medicine, a sports physiotherapist, a podiatrist and a dietician. The team had access to a clinical psychologist and referred patients who would benefit from this.

A local non-profit youth violence intervention organisation had established a team in the ED to provide immediate support to patients who presented with injuries, mental health needs or safeguarding needs relating to gang violence or sexual exploitation. The team worked with clinical staff in coordinating the holistic care of patients with knife injuries or other violence-related needs and intervened at critical moments to prevent the patient becoming further involved with exploitation and abuse.

The older people’s assessment and liaison (OPAL) team reviewed patients who were ready to be discharged within 24 hours and who were not awaiting diagnostic or blood results.

Where patients who received hospice-based non-invasive ventilation (NIV) presented repeatedly in the ED, the specialist respiratory team liaised with the hospice to identify areas of unmet need in the community.

The ED and Wellcome Short Stay teams had developed a spinal pathway to meet the needs of patients more quickly. This meant the ED team would initially assess patients with a spinal injury, arrange a scan and then transfer them directly to the Wellcome Short Stay unit. Spinal theatres were co-located with the Wellcome centre, which further improved coordinated planning for patients.

A consultant and clinical nurse specialist provided immediate care for hand injury patients presenting in the ED, including patients with ‘dirty wounds’, such as animal bites, using a ‘hot hands’ clinic. This meant staff referred patients directly to the specialist team who admitted the patient to ambulatory care to assess them for suitability for surgery. This helped reduce the pressure on the ED team who had experienced an increase in hand injury patients in the previous year. The senior divisional team had recognised the success of the hot hands clinic in reducing the trauma list and promoted the development and implementation of the pathway as an
exemplar for similar development. For example, the senior team was in the process of developing a similar pathway for ear, nose and throat (ENT) and maxillofacial treatment.

Urgent and emergency services did not routinely treat children as paramedics took these patients to a nearby specialist children’s hospital. However, the ED had the capacity to treat children in an emergency. Consultants were trained in paediatric emergency care and the resuscitation area had a bay equipped with neonatal and paediatric equipment.

Elderly, frail and vulnerable patients who received community-based care were at risk of losing their package of care if they were admitted to the hospital for over 48 hours. This would result in a significant delay in discharging them back to their home and would generate substantial challenges for hospital liaison teams. To address this risk the OPAL team worked to treat patients rapidly in the CDU and discharge them in less than 48 hours to protect their package of care.

A four-bedded high dependency unit (HDU) in the CDU, called CDU Assist, provided level two care to acutely unwell patients. Level two care is classified by the Intensive Care Society as a patient who requires single organ support. CDU staff worked with colleagues from critical care to assess patients who were treated in ED resuscitation to transfer them safely without the need for an intensive care admission. CDU assist provided care and treatment for patients who deteriorated in the ED or CDU and provided staff with assurance they could provide advanced care for patients with acute needs.

Emergency nurse practitioners (ENPs) provided care and treatment for patients who presented in the ED with minor injuries and illnesses, including ear, nose and throat (ENT) and maxillofacial conditions. The ENP team provided a review clinic for patients who needed ongoing wound care or fracture assessments. The team offered the clinic from 9am to 1pm Monday to Friday in addition to the minor injuries and illness services.

Staff were working with community mental health teams to reduce high ED attendances as part of a commissioning for quality innovation (CQUIN) goal. The team had exceeded their target of 20% reduction in attendances in 2017/18 and achieved a 40% reduction in attendances amongst the target group. Extended work included ensuring patients had care plans and appropriate support strategies in place to promote good health and wellbeing in the community.

The hospital had plans in place to support patients who frequently attended the CD with mental health needs, linked with the CQUIN. We saw examples of this being discussed within the Rapid Assessment Interface Discharge handover meeting and clear management and escalation plans in place to reduce the likelihood of readmission. We were told there used to be a multidisciplinary frequent attenders meeting but this had recently ceased.

A consultant and physiotherapist led the NIV service, which included a team of physiotherapists. The team reviewed their efficacy, responsiveness and impact using an audit in 2016/17 that demonstrated an 80% clinical effectiveness rate following an acute NIV episode. The audit highlighted good standards of compliance with 2017 national confidential enquiry into patient outcomes and death (NCEPOD) recommendations in relation to the delay in initiating NIV outside of inpatient wards.

The hospital had access to a local crisis resolution and home treatment team, provided by another NHS trust. The team operated 24-hours, 7 days a week and offered assessment and home treatment for people over 16 experiencing a mental health crisis as an alternative to hospital admission.

Children under the age of 16 who presented with a mental health crisis were supported by a specialist organisation. Forward Thinking Birmingham, part of Birmingham Women’s and Children’s NHS Foundation Trust.
The CDU was awaiting the appointment of a social worker to support with patient safeguarding and liaison with the local Section 136 place of safety suite.

The physiotherapy team was scoping the need for a clinical specialist in older people’s medicine to be based permanently in the CDU, as part of the OPAL team. This was in recognition of the significant year-on-year increase of older people seen in the department. The team wanted to establish if an increase in physiotherapy cover would improve the outcomes for older patients, particularly those with needs relating to frailty.

The respiratory support team saw all patients who attended with an acute episode of asthma or COPD and ED staff used PICS to trigger an automatic referral to the team. The team had a standard response time of 45 minutes from initial referral, including at weekends.

Occupational therapists (OTs) working in the OPAL team had an urgent referral standard of 45 minutes and three hours for non-urgent referrals for patients referred from the CDU.

A specialist physiotherapist in sports medicine was based in the ED and provided a dedicated service to patients presenting with sports-related injuries. This reduced pressure on the medical team and meant patients had their specific needs met without the need for admission or lengthy referral delays. The physiotherapist referred patients directly to the musculoskeletal (MSK) service, which avoided the need to attend the fracture clinic. The physiotherapy team used a new standard for ankle sprains, which meant patients could complete the whole care and treatment pathway without the need to see a consultant. This meant patients had more direct access to care and reduced the pressure on other services.

**Meeting people’s individual needs**

The trust scored about the same as other trusts for all of the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Dedicated volunteers worked in the ED and supported patients and their relatives by serving food and drinks and providing companionship. The volunteers were uniformed, wore name badges and proactively approached people to talk to them.

Staff ensured patients benefited from multidisciplinary working and adapted care to meet their individual needs. For example, where staff initiated NIV and it subsequently became clear the patient could be better cared for with a palliative care plan, the specialist physiotherapy team weaned the patient and worked together with the palliative care team. Doctors provided medical oversight and updated the electronic patient records system to prevent staff from delivering active intervention and to start comfort observations instead. The occupational therapy team sourced home equipment for patients within four hours, such as an air mattress to prevent pressure sores.

Staff provided information on waiting times using a TV screen in the waiting area. This included the expected current waiting time for patients to be seen following initial triage and the number of patients currently in the department. They also included information on alternative local services.
that may provide a more appropriate alternative for treatment, such as urgent care centres. The waiting area included a designated children’s area.

Reception staff provided patients and their relatives with additional support, such as booking taxis and printing discharge letters.

Staff had rapid access to diagnostics including CT scans and x-rays 24-hours. Doctors and senior nurses told us access to scans was reliable and consistently good and even at the busiest periods they rarely had to wait.

The CDU team using a cohorting technique to accommodate patients with reduced levels of mental acuity or perception into a dedicated area of the unit. This meant they cared for patients with conditions such as dementia, delirium and drug and alcohol-related needs in a single area. This enabled the team to concentrate staff with skills in caring for such patients in the area and provide enhanced supervision of patients.

Two single-patient side rooms in the CDU had been refurbished as bespoke spaces for patients with mental health needs. Ligature points had been removed and railings and curtains were collapsible, to prevent patients from self-harming. Both rooms had windows visible from the nurse station and the team had secured funding from a charitable organisation to decorate both rooms with ‘living wallpaper’, which provided a more inviting, desensitised environment for patients living with dementia. Side rooms with either natural or artificial light were available and staff cared for patients in the room most appropriate to their mental health status.

Staff used the triage process in an effective and responsive way that meant patients with the most immediate needs were prioritised. For example, we observed ENPs who saw a patient in the minors stream identified they needed a partial finger amputation. The team referred the patient for an immediate x-ray and liaised with the specialist hand team to secure an immediate referral.

The ED was undergoing refurbishment to provide a mental health assessment room, a relative’s room and a new triage room. This was due for completion in December 2018 and would enable staff to offer a significant improvement in use of spaces to meet individual patient needs.

Staff had access to resources to help them communicate with patients with additional or complex needs relating to dementia or learning disabilities, including a sensory box. Books, puzzles and crosswords were available as well as toys for children.

Allied health professionals (AHPs), the CDU clinical team and the OPAL team were collaborating in the national flow coach academy to work with community providers to improve individual care assessment and delivery. The team were testing the pathway that saw patients move from initial presentation in the ED to the CDU and ultimately to discharge. The project enabled staff to test the responsiveness of the pathway in real time with patients rather than retrospectively with data.

A medical consultant and a consultant physiotherapist led a sport and exercise clinic that assessed patients for exercise-related injuries as part of an exercise referral pathway from ED.

The ED and CDU both scored the maximum 100% in the 2018 patient-led assessment of the care environment (PLACE) audit for the disability score and the ED scored 96% for the dementia care measure. The CDU was not rated for this measure.

Staff supported patients with a learning disability to communicate with a range of specialist tools that were stored in a communication box. This contained pictures of common symptoms and messages in an emergency department, an alphabet chart, a hearing aid and a magnifying glass. Staff told us they worked closely with the relatives and carers of people with a learning disability to
understand their needs. The provider had developed an ‘all about me’ booklet for patients and their relatives and carers to complete upon admission to the hospital to support staff to personalise the patient’s care. This included information about the person’s preferences for eating and drinking, hygiene, mobility, sleep and rest, going to the toilet and dressing. This was part of the trust’s dignity in care initiative. The trust had a designated lead for supporting patients with a learning disability who was accessible for staff to contact for advice and support.

The RAID team had a target time of one hour from referral to assessment for patients referred from the ED, four hours for patients referred from the CDU and 24 hours for patients referred from any other area of the hospital. In August 2018, 71% of the patient referrals made by the ED team were seen by the RAID team within the target time of one hour. During the same time period, 78% of the patient referrals made by the CDU where seen by the RAID team within the target time of four hours and 59% of the patient referrals made by the rest of the hospital were seen by the RAID team within the target time of 24 hours.

The RAID team met every morning to run through a detailed handover of the non-urgent care patients and allocate assessments and appointments to the most appropriate professional within the team. The team attended a full multidisciplinary team meeting weekly to review any patients who had been open to RAID for two weeks or longer to address their needs.

The hospital had developed a pathway for patients who attended the ED presenting with a mental health concern. Patients who were admitted to the ED were transferred to the CDU where staff had support from the mental health liaison team. This was introduced to try to reduce the misdiagnosis of mental health problems and offer patients the most appropriate care and treatment through liaison with the RAID team and signposting to external agencies.

When appropriate, community mental health teams (CMHTs), community learning disabilities teams (CLDTs), child and adolescent mental health teams (CAMHS) or similar, were copied into discharge correspondence.

Staff within the hospital had raised money to buy electronic book readers for patients within the hospital to use whilst waiting for an inpatient mental health bed to become available. This was in response to concerns that boredom and frustration had resulted in an increase in aggressive incidents.

Staff used a discreet visual flagging system to indicate when a patient had additional needs relating to dementia, learning disabilities or safeguarding. Staff also used this to identify patients who had been violent or aggressive and noted if they had been given a yellow or red card as part of the warning system to protect staff from harm.

Paramedics and nurses routinely referred to the psychological and emotional needs of patients during handovers. They provided clear instructions regarding observations of patients who presented a risk to themselves or others. The rapid assessment interface discharge (RAID) and mental health liaison team gave regular updates to the teams to keep them informed of changes in patients’ presentation and needs.

**Access and flow**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour.

Queen Elizabeth Hospital did not meet the standard over the 12-month period from July 2017 to June 2018. The trust also performed worse than the England average across the entire reporting period.
In April 2018 the other sites met the standard and had a median time lower than the England average by two minutes. From May 2018 onwards these sites reported times higher than both the standard and the national average.

The trust has submitted the below figures for the median time from arrival to treatment for August 2017 to March 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>University Hospitals Birmingham NHS Foundation Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>65</td>
<td>53</td>
</tr>
<tr>
<td>Sep-17</td>
<td>73</td>
<td>58</td>
</tr>
<tr>
<td>Oct-17</td>
<td>78</td>
<td>59</td>
</tr>
<tr>
<td>Nov-17</td>
<td>81</td>
<td>60</td>
</tr>
<tr>
<td>Dec-17</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>Jan-18</td>
<td>84</td>
<td>57</td>
</tr>
<tr>
<td>Feb-18</td>
<td>85</td>
<td>61</td>
</tr>
<tr>
<td>Mar-18</td>
<td>85</td>
<td>64</td>
</tr>
<tr>
<td>Apr-18</td>
<td>76</td>
<td>60</td>
</tr>
<tr>
<td>May-18</td>
<td>72</td>
<td>61</td>
</tr>
<tr>
<td>Jun-18</td>
<td>76</td>
<td>62</td>
</tr>
<tr>
<td>Jul-18</td>
<td>90</td>
<td>64</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - A&E quality indicators)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018 the trust failed to meet the standard and performed worse than the England average in every month, other than in December 2017 when trust performance exceeded the average.

Four hour target performance - University Hospitals Birmingham NHS Foundation Trust
The trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average in August 2017 and from December 2017 to March 2018. From September to November 2017 and from April 2018 onwards the trust’s performance was worse than the England average.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - University Hospitals Birmingham NHS Foundation Trust**

The following table shows the monthly number of patients waiting more than four hours to admission:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>177</td>
</tr>
<tr>
<td>Sep-17</td>
<td>491</td>
</tr>
<tr>
<td>Month</td>
<td>Value</td>
</tr>
<tr>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Oct-17</td>
<td>590</td>
</tr>
<tr>
<td>Nov-17</td>
<td>443</td>
</tr>
<tr>
<td>Dec-17</td>
<td>262</td>
</tr>
<tr>
<td>Jan-18</td>
<td>782</td>
</tr>
<tr>
<td>Feb-18</td>
<td>639</td>
</tr>
<tr>
<td>Mar-18</td>
<td>702</td>
</tr>
<tr>
<td>Apr-18</td>
<td>1,889</td>
</tr>
<tr>
<td>May-18</td>
<td>1,850</td>
</tr>
<tr>
<td>Jun-18</td>
<td>1,689</td>
</tr>
<tr>
<td>Jul-18</td>
<td>1,755</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E SitReps).

Over the 12 months from August 2017 to July 2018, two patients waited more than 12 hours from the decision to admit until being admitted. These occurred in August 2017 and May 2018 with one patient waiting more than 12 hours in both months.

(Source: NHS England - A&E Waiting times)

From August 2017 to July 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was worse than to the England average, with null returns from the trust in April – July 2018.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - University Hospitals Birmingham NHS Foundation Trust

![](chart.png)

(Source: NHS Digital - A&E quality indicators)

The trust submitted two separate sets of figures for the total time spent in A&E per patient from April to July 2018, one for Queen Elizabeth Hospital and a combined figure for the other trust sites.

From August 2017 to July 2018 the monthly median total time in A&E for all patients at Queen Elizabeth Hospital was higher than the England average. Similarly, the median time for the other trust sites was higher than the England average from April to July 2018.
### Table: Queen Elizabeth Hospital, Other Sites, England

<table>
<thead>
<tr>
<th>Month</th>
<th>Queen Elizabeth Hospital</th>
<th>Other Sites</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>170</td>
<td></td>
<td>144</td>
</tr>
<tr>
<td>Sep-17</td>
<td>176</td>
<td></td>
<td>148</td>
</tr>
<tr>
<td>Oct-17</td>
<td>185</td>
<td></td>
<td>148</td>
</tr>
<tr>
<td>Nov-17</td>
<td>186</td>
<td></td>
<td>152</td>
</tr>
<tr>
<td>Dec-17</td>
<td>174</td>
<td></td>
<td>159</td>
</tr>
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<td>Jul-18</td>
<td>191</td>
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</tbody>
</table>

(Source: NHS Digital - A&E quality indicators)

The site team led bed meetings four times each day, which were attended by the divisional director of operations, the CSM, the divisional operations manager and the hospital ambulance liaison officer (HALO) in additional to senior staff from each specialty. We attended two bed meetings, which highlighted the pressures on the service. During one bed meeting the ED team highlighted ongoing pressures to the service. This included 14 patients awaiting beds without a confirmed placement, a patient in the department who had waited over 13 hours and 12 nurse absences expected over the next three shifts. At the next bed meeting the maximum wait had reduced by over six hours although an additional two patients were awaiting admission. However, there was evidence of sustained work from the discharge team and site team and 40 patients were due for discharge by the end of the day. The senior team reviewed performance in the previous 24 hours, which included 113 ED breaches of the four hour wait target and 46 delayed transfers of care.

A divisional team and heads of therapies had launched an improving emergency flow project that involved working more closely with inpatient wards and placing an occupational therapist on ward 518, an older people’s ward. The therapist was trained in discharge planning, could order equipment for patients’ arrival home and worked with the local authority to reach an agreement that the therapist could approve a social care package, in collaboration with social workers, of up to four home visits per day. This project had reduced the length of stay for this patient group by 2.6 days and identified substantial multidisciplinary work undertaken to reduce unnecessary time spent in the hospital.

A HALO was based in the main 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.

The GP service saw up to 25 patients per day 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.

The OPAL team prioritised patients in the ED at weekends when the service was led by two members of staff. Where demand in the ED was high, the team could not always see patients in the CDU. In each case the electronic patient records system identified that patients were awaiting a therapy review and would be reviewed as a priority when the next shift started. A physiotherapist was allocated to reviewing weekend referrals on Monday mornings, which meant...
these patients were seen immediately and a backlog did not contribute to delays for other patients in the department.

The OPAL team tracked referral and treatment data to establish the impact of the service and to plan staffing and resources. From June 2018 to September 2018 the team saw between one and 17 patients per day in the ED, among which a median of one patient was discharged directly from the ED, three patients were discharged the same day and one patient transferred to the emergency observation unit (EOU). This median data demonstrated the effectiveness of the service and how it reduced pressure on the ED. During this period an average of 175 patients were seen in the CDU by an OPAL nurse and 90 patients were seen in the ED by an OPAL nurse. Patients seen by OPAL consultants and the MDT team varied from 18 per month to 95 per month.

Speech and language therapists (SaLTs) and dieticians provided care in the CDU and worked across medical specialties. SaLTs we spoke with said this wide area of responsibility left the service stretched and patients often left the CDU before the team could review them.

Staff had established systems and care pathways in the AMC and EOU to reduce the amount of time patients spent waiting to see different members of staff. For example, physiotherapists saw patients whilst they were waiting for blood results.

Staff worked between divisions to support the capacity and flow of the main ED. The division A leadership team had extended the opening hours of the ambulatory care unit on Sundays as an additional space for patients to reduce the pressure on ED.

The ED team planned to open a dedicated rapid access, triage and treatment (RATT) unit in December 2018. This represented a long-term multidisciplinary project with significant input from staff at all levels of the ED team and leadership from senior nurses. The RAT service would focus on ambulatory care streams, which senior nurses identified as being under-utilised.

ED nurses had undertaken a nursing knowledge programme, which enabled them to assess commonly-presenting medical problems and provide more information in advance for the medical team. This enabled doctors to begin decision-making processes sooner and reduce delays in establishing care and treatment plans.

The senior team in ED had established a series of processes they implemented with time to initial assessment began to increase due to demands on the department. This included 30-minute interventions led by the overall nurse in charge to identify patients who could be quickly assessed and treated elsewhere. The CDU nurse coordinator triaged medical patients waiting in the ED during busy periods and transferred patient to the CDU’s ambulatory space where this was safe.

A dedicated CDU discharge team had been implemented in January 2018 to coordinate discharge after a consultant had made the decision. The team liaised with other staff involved in care to ensure everything was in place that needed to be, such as prescriptions and instructions for follow-up. This team and process had reduced the average discharge time from five hours from the patient being ready to one hour and improved the average time of day at which patients were ready for discharge from 3pm to 1pm and increased use of the discharge lounge by over 300%.

The division had opened the EOU in November 2017 as an innovative strategy to relieve pressure on the main ED and improve patient flow. Staff used a specific care pathway to ensure only low-risk patients were seen in the unit, such as those waiting for test results or experiencing symptoms of low-risk asthma or renal colic.

The CDU senior nurse coordinator worked closely with ED colleagues to place patients who had a decision to admit status, which meant a consultant had made a decision to refer them to an
inpatient medical specialty. This approach meant patients spent less time in ED, which improved capacity in the department and meant patients spent less time waiting.

The 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 lead nurse and consultant for OPAL worked with ED colleagues to improve the identification of patients suitable for the service who could be immediately transferred. They achieved this by presenting pathways to ED staff and working together to assess patient suitability and safety for transfer out of the ED and to an OPAL assessment in the CDU.

A dedicated transfer team, based on ward 516, supported staff and patients in the CDU. Team members worked with the CDU coordinator to ensure the timely transfer of patients to inpatient wards. The implementation of a transfer team reflected the proactive, exploratory approach of the CDU and ED teams in reducing delays in access and flow. For example, the CDU team carried out a time and motion study during post-take ward rounds and identified delays of up to five hours in transferring each patient to an inpatient bed. To address this the transfer team and discharge teams worked more substantively with the CDU team to promote timely access.

Therapies teams organised wheelchairs and supportive seating for patients who had experienced a major trauma to take home. The equipment was serviced monthly through a service level agreement and was tracked for automatic recall when a patient left the service’s care. This meant equipment remained useful and safe for patients and reduced the risk equipment would be lost in the community. The therapies department had a dedicated workshop for spares and modification, such as for making walking sticks to measure.

The ED and CDU teams trialled an improving emergency flow week in June 2018. This involved the implementation of consultant-led rapid assessments from 9am to 1pm for ambulance patients, 24-hour pharmacy cover and 100% of patients admitted to the medical take. The trial resulted in a number of significant improvements including a 55% reduction in breaches against the four-hour admission target for all medical specialties and 55 fewer hours spent on CDU. The project team identified nine key areas of investment needed to implement the trial on a permanent basis, some areas of which were in development.

The mental health liaison team completed a daily report to clinical site managers and the RAID team to highlight how many patients required mental health support, including observations.

The OPAL team completed a daily handover to keep track of all their patients, who remained under the team’s care to maintain consistency.

Learning from complaints and concerns

From April 2017 to March 2018 there were 179 complaints about urgent and emergency care services across the trust as a whole. The trust took an average of 38 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be resolved within 30 working days.

Of the 14 complaints still open at the time of reporting all had been open longer than the trust target of 30 working days, the longest being open for 236 working days.

At Queen Elizabeth Hospital there were 100 complaints. The main themes were clinical treatment with 31 complaints (31%), staff with 25 complaints (25%), patient care including nutrition / hydration with 14 complaints (14%) and communications with 14 complaints (14%)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
From April 2017 to March 2018 there were 148 compliments within urgent and emergency care. The breakdown by site is shown in the table below.

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<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>98</td>
<td>66.2%</td>
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<tr>
<td>Birmingham Heartlands Hospital</td>
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<tr>
<td>Good Hope Hospital</td>
<td>17</td>
<td>11.5%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>9</td>
<td>6.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>148</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

From April 2018 to October 2018 the division received 79 complaints relating to the ED, AMC and CDU with 10 key themes including clinical treatment, staff attitude and administration. In each case the trust demonstrated a timely acknowledgement, a truthful response and apology and identification of learning where appropriate.

The senior divisional team said they were proud that no complaints had been received from patients cared for in the corridor queuing system. This was evidence of the continual communication offered by staff and effective teamwork in establishing treatment plans.

A theme amongst complaints received about the CDU had related to patients being discharged with cannulas in situ. The matron and senior divisional team identified the workload as a key factor. They addressed this with the introduction of structured pastoral support and the results of a workforce review, both of which had resulted in improvements and in the six months leading to our inspection no similar complaints had been made.

Divisional staff said they received an average of one complaint per 1000 patients in the ED.

Divisional teams used a patient relations report to monitor monthly trends in complaints and PALS concerns including changes in trends, key themes and response timeframes. Where teams took longer than the trust 30-day resolution target, staff involved in the investigation documented reasons for this. Clinical treatment, communication, patient care and staff attitude were the four most common complaint themes and none of the medical wards were outliers for the number of complaints received. Between April 2018 and June 2018, the ED, CDU and AMC accounted for 42% of the complaints received in the division.

Is the service well-led?

Leadership

A matron for the emergency department (ED) and a matron for the clinical decision unit (CDU) led the day to day running of the units. The CDU matron led the acute medical centre (AMC) and the emergency observation unit (EOU). The departments came under division C and a triumvirate senior leadership structure was in place, which included a clinical director, divisional head of nursing and a general manager.

Leadership was visible during each shift, with lead clinicians and senior nurses readily identifiable and accessible.

Most staff we spoke with said they considered leadership and management teams to be accessible, responsive and supportive. Staff said they were taken seriously when presenting ideas
for new initiatives or projects and felt confident to speak up when they were worried or concerned. ENPs we spoke with said they rarely saw senior staff above matron level and they were largely disconnected from the consultant team.

Staff working in the mental health teams reported line managers and the senior managers within the organisation to be supportive and approachable.

**Vision and strategy**

The trust had an overarching, well defined vision and strategy that was highly visible throughout the hospital. Staff had access to the details of this on the intranet and senior staff embedded it in meetings and staff engagement exercises. All the individuals we spoke with understood how the trust’s vision and strategy applied to them and their area of work and said they felt it helped to improve teamwork.

The mental health liaison team worked to the NHS England 2016 Five Year Forward view for mental health services and the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) Treat as One report, including through the integration of care delivery across specialist services.

The development of a rapid access, triage and treatment (RATT) unit was the main strategic and developmental focus of the ED for 2018 and was due to be implemented in December.

**Culture**

Senior nurses offered debriefs at the end of shifts when they identified staff would benefit from this, such as particularly stressful shifts. A named nurse was the lead for staff wellbeing and worked with the wider team to improve resilience and make the department a more supportive, pleasant place to work. This approach was embedded in the working culture and one senior nurse said it was their role to, “Make staff valued enough to want to work here.”

Most staff we spoke with spoke positively about their work. “Staff culture is good and we’re supported by the CEO. We’ve got a sharp team that works hard and works well together.”

Junior doctors in the ED felt the department offered them a lot in terms of training, development and support and said consultants were readily accessible. They said they felt valued for their contribution although workloads were very high and they often felt very stressed. Similarly, registrars said the ED offered them valuable experience and development opportunities although rota patterns were erratic and made it difficult to achieve a good work-life balance.

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.

The culture of continual learning and supporting staff to advance was embedded in every aspect of service delivery and development. For example, the OPAL team found new nurses and doctors in the ED and CDU were not always aware of the role of the team or their care pathways. To facilitate a culture of learning and education, the team had a policy of accepting all referrals, even if they were inappropriate. Where this happened, they worked with the referring member of staff to help them identify more appropriate alternatives.
Staff spoke positively of the working culture in their respective teams, including the working relationship with senior staff had enabled them to contribute project and research ideas. They also said their achievements were recognised and they felt valued for their contribution.

The implementation of the mental health liaison team in the CDU significantly improved staff morale. The team had previously reported high levels of stress from the lack of training or referral support for patients who presented with significant mental health needs. The liaison team provided structured training and support to address this, including debrief conversations and facilitated reflective practice.

**Governance**

Governance structures were divided into two key types; those held at divisional level and those held at service specialty level. Governance processes included for quality improvement, risk management and safety and performance reviews.

Consultants led a weekly trainee doctor meeting that provided clinical governance assurance through case studies, patient reviews and training cases. Doctors supplemented this with monthly case reviews and monthly morbidity and mortality (M&M) meetings during which they reviewed all patient deaths.

The guardian of safe working (GSW) and the junior doctors monitoring team monitored exception reporting daily Monday to Friday and directed reports to consultant exception reporting (ER) leads in clinical specialties and departments for action. Junior doctors and local negotiating committees (LNC) representatives scrutinised reports during quarterly guardian exception reporting review group (GERRG) meetings. The trust actively facilitated access to the ER system and gave junior doctors immediate access to the reporting system during their induction. The junior doctors monitoring office maintained oversight of exception reporting over the academic year, which ran from August to July. In 2017/18, junior doctors submitted 125 exception reports, of which the GSW identified five as significant and one that represented an immediate safety risk. Groups responsible for monitoring and clinical governance worked together to stabilise rotas and respond quickly to gaps in planned staffing and consultant ER leads demonstrated continual improvement in the monitoring of working hours. The GERRG monitored rota gaps as part of clinical governance oversight and in July 2018 there were 2.2 whole time equivalent (WTE) gaps.

All the staff we spoke with demonstrated knowledge of the duty of candour, including their responsibilities and the circumstances under which it should be used.

Individual teams established their own governance processes to drive improvements and chance. For example, emergency nurse practitioners met monthly to share information and discuss learning and challenges.

Senior nurses had protected administration time each month for audits and to process incident reports. Nurses in this team were knowledgeable about the risk register and the governance aspects of the ED, including reporting trends and key risks and challenges. Although senior nurse ownership of audits in the ED was evidence of good practice, there was limited assurance of understanding and leadership at a more senior level. For example, the matron did not have an overview of recent audits and outcomes and was unable to locate these.

Royal College of Defence Medicine clinicians were subject to the same governance arrangements as NHS staff and were accountable to the military deanery.

The mental health liaison team had been invited to present to the quality care group within the organisation to highlight their impact on patient and staff care.
Management of risk, issues and performance

Staff used risk registers to identify, track and resolve risks to their services. Risk registers were maintained at divisional level and service or team level. For example, the division C risk register included risks appropriate to all services in the division or to the division at an operational level.

As of October 2018, 14 risks applied to each of the ED and the CDU and one risk applied to the EOU. Five risks in each of the CDU and the ED were classed as significant and all others were low or moderate. All risks had documented mitigating actions although it was not evident regular reviews took place or why some risks had remained on the risk register for significant periods of time. For example, one significant risk in the CDU related to the high risk of falls of patients. This had been entered on the register in 2009. Another significant risk, also documented from 2009, related to the potential injury to patients leaving the unit unsupervised. Staff were aware of the risks but there was a lack of assurance that appropriate action to resolve them had taken place in the nine years they had remained on the risk register.

Physiotherapists and other therapies maintained risk registers specific to them, which applied to the care they delivered to specialties within the division. Staff entered risks on more than one risk register where the impact was relevant to both. For example, the musculoskeletal (MSK) service was entered on the risk register for the ED and the risk register for physiotherapy as this applied to physiotherapists providing the service in the department. The accountable staff for each risk reviewed them annually as a minimum standard to identify progress or changes in the severity of the risk.

Procedures were in place for reception staff in the ED to manage risks associated with aggressive visitors or unacceptable behaviour. This included rapid response access to the site security team, panic alarms at each desk and automatic shutter closure.

The senior divisional team recognised overcrowding as a key risk in the ED and said this had worsened significantly in the previous two years. The team had implemented a range of initiatives to mitigate this, such as the introduction of a GP and advanced medical practitioners, a physiotherapy service and the development of new clinical pathways to redirect patients.

Staff cared for patients in multiple different areas, including subsections of departments. However, coordination and escalation processes were embedded and coordinators demonstrably worked closely together to manage waiting times during periods of high demand.

Link nurses in the CDU carried out quality audits from January 2018 to March 2018 in their individual areas of expertise. Audits included standards of safety checks of resuscitation trollies, consistency of waterlow assessments, completeness of patient records, nutrition audits and hypoglycaemia box checks. Staff presented their results to the harm prevention group and in each case demonstrated how they had addressed areas for improvement. This included liaison with colleagues to improve the consistency of daily responsibilities and more sustained work with specialty leads. For example, the nutrition link nurse worked with the dietetics team to increase nurse training. This led to a 90% completion rate of nutrition training and subsequent improvement in practice. The diabetes link nurse established a new monthly audit standard and checklist for hypoglycaemia boxes, which resulted in a 20% improvement in compliance with safety checks.

Trauma research nurses attended every crash call as a procedure that meant if the ED resuscitation unit was short-staffed, the nurses provided support. This meant the resuscitation unit had the assurance of staffing support as a risk reduction measure.

Divisional preventing harm groups met monthly and reviewed clinical governance and departmental performance and risks. We looked at the minutes of meetings that took place in June
2018, July 2018 and September 2018. Staff were proactively involved in preventing harm team work and contributing learning from projects and research. For example, nurses from the service improvement group presented their findings from observational research they had carried out on inpatient wards into handover processes.

The mental health liaison team monitored performance and from February 2018 to April 2018 the team carried out 150 interventions for patients with psychiatric conditions and carried out 114 instances of staff training in risk assessing and managing patients with psychiatric conditions. The team carried out a staff satisfaction survey to identify their impact in the context of previous CDU staff survey results that they felt poorly equipped to provide care for patients with mental health needs. The survey result indicated 100% of CDU staff felt better supported and more knowledgeable. Staff reported feeling less anxious and more confident and said they felt it had improved patient care as a result.

The ED matron noted mental health bed provision and aggression and violence towards staff as key risks on the department risk register. Clinical Educators, the rapid assessment interface discharge (RAID) team and a mental health educator were delivering a training programme to help staff improve their de-escalation skills and ability to manage challenging situations.

Information management

Staff undertook information governance training and demonstrated a good understanding of their responsibilities under the General Data Protection Regulations 2016/679, including in relation to safe data storage.

The CDU coordinator had a work space that presented an information governance risk. This was because the space was based in the recess of a corridor and access could not be fully controlled. The matron and nurse coordinators demonstrated awareness of this and complied with trust policies to limit the risk, such as securing computers when they were not attended. The senior team were developing future plans to convert an office into a dedicated coordinator hub that would ensure high standards of information governance.

From April 2018 to October 2018 staff reported 13 incidents relating to information governance, which reflected less than 1% of the total incidents reported.

Engagement

The CDU matron acted on risks to staff wellbeing caused by high levels of stress and the impact of caring for patients with significant mental health needs. They had developed a system to secure interventional counselling for staff to prevent the risk of sickness. Staff told us this meant they felt better and performed better and said they rarely felt burnt out, which was a significant improvement on previous working conditions.

Clinical Educators were working with teams across the hospital to develop a trust initiative of building team skills around human factors. To achieve this, they included human factor discussions in scheduled training and incorporated discussions about human and team behaviour and emotional intelligence in scenario-based simulation training.

Staff had acted on patient feedback regarding facilities in the AMC, including the provision of snacks and drinks and charging ports for mobile phones. This feedback related to patients admitted unexpectedly to the AMC who could not contact relatives because they did not have a mobile phone charger.
We reviewed seven staff feedback forms about the mental health liaison team. All staff reported feeling more confident and knowledgeable about how to support patients with mental health needs and that the team were very helpful.

**Learning, continuous improvement and innovation**

The senior team recognised the need for future succession planning to ensure the ED remained a sustainable service. Part of this plan included providing staff with extended development programmes, such as the advanced clinical practitioner pathway. This ensured the ED maintained a highly skilled workforce and improved retention by making it an attractive place to work for staff with professional development ambitions.

The allied health professional (AHP) team was research active and a dedicated research physiotherapist encouraged colleagues to develop research that would improve patient outcomes and experience and provide them with valuable professional development experience. The AHP team held a bi-monthly research meeting that colleagues used on a drop-in basis to discuss their ideas and plans.

CDU nurses presented the results of their work to implement point of care flu testing in the CDU at Society for Acute Medicine conference. The initiative had contributed to a hospital-wide intensive programme to prevent access to visitors showing signs of flu infection, implement ready access to flu vaccination and care for patients with a flu risk in controlled side rooms. As a result, the hospital had experienced no ward closures during the winter 2017/18 period due to flu outbreaks.

ED and CDU teams continually sought service and performance improvements through trials, pilots and innovative projects. For example, the CDU matron was working with the manager of the porter team to identify staff who would be interested in working shifts dedicated to the CDU. This would be a pilot and involved porters who held HCPA registration so that they could recognise patient deterioration during a transfer. The matron planned for the pilot to demonstrate if a porter team based in the department at peak times would reduce transfer or discharge delays.

A consultant, nurse and pharmacist formed a research service implementation group and established a strategy to significantly increase staff engagement with research and projects. They established a dedicated e-mail address and drop-box for anonymous feedback and suggestions. The group encouraged all staff, at any level of seniority and in any role, to engage with them and discuss research ideas. This was linked to governance processes and the group identified opportunities to link project proposals with items on the risk register as well as incidents and complaints.

Allied health professionals had won a best in therapy for trauma care award in recognition of excellent care.

A multidisciplinary service improvement group in the CDU worked to explore opportunities for new ways of working that would improve patient experience, outcomes and performance. The group had secured presentation slots for 10 research and audit posters at a trust event and had implemented a dedicated quality improvement e-mail address for staff to contact them with ideas. The team had visited wards and spent time with colleagues elsewhere in the hospital to opportunistically identify areas for improved working. For example, members of the team had carried out observations of handovers in a sample of inpatient wards to gather ideas for improved processes that could be developed in the CDU.
Medical care (including older people’s care)

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

The medical care service at University Hospital Birmingham NHS Foundation Trust provides care and treatment for a wide range of specialties including:

- cardiology
- colorectal
- diabetes
- endoscopy
- infectious diseases
- neurology
- oncology
- renal
- respiratory
- stroke

There are 1,579 medical inpatient beds located across 56 wards plus 17 beds on a multi-specialty ward for private patients at Queen Elizabeth hospital.

The trust also provides acute medical care at Birmingham Chest Clinic, Castle Vale Renal Dialysis Centre and Runcorn Road Renal Dialysis Centre.

(Source: Routine Provider Information Request (RPIR) – Sites – All tab)

Specialist elderly care services operate across the Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital sites with a frailty ambulatory emergency care available on the medical day units (MDU) at both Birmingham Heartlands Hospital and Good Hope Hospital. Teams are multi-professional and assess patients in the emergency department who are suitable to be managed in the MDU as an ambulatory patient. The team also carry out comprehensive geriatric assessments, instigate and carry out appropriate diagnostics and interventions with the aim to return the patient to their usual place of residence with or without support services. At Solihull Hospital ambulatory care is provided via the frailty advice and support team who operate out of the medical day unit.

Additionally, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital provide ortho-geriatric support to the trauma and orthopaedic wards and all geriatricians run afternoon outpatient clinics.
There is also a well-established dementia and delirium team which works across all of the complex elderly care wards at all three sites and aims to educate staff, patients and carers on dementia and delirium care.

(Source: Acute Provider Information Request (RPIR) – Context acute HGS tab)

A site breakdown can be found below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
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<tr>
<td>Queen Elizabeth</td>
<td>Bournville ward</td>
<td>Older adults</td>
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<tr>
<td>Hospital Birmingham</td>
<td>Coronary care unit</td>
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<td>Harborne ward</td>
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<td></td>
<td></td>
<td><strong>653</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites – All tab)

The ambulatory care unit operates as a nurse-led elective care area with a broad clinical case mix. The unit has 24 overnight beds and 57 trollies including four medical isolation bays. The unit admits approximately 70 patients daily.

The cardiac catheter laboratories carry out approximately 1200 percutaneous coronary intervention (PCI) procedures per year.

The inpatient endoscopy service includes a dedicated inpatient facility, which runs six lists solely for inpatients and provides diagnostic and therapeutic procedures. The inpatient facility is also used to support the delivery of a 24-hour emergency bleed service, staffed by the endoscopy team.

Endoscopy is delivered by a number of differing specialities including: gastroenterology, colorectal surgery, general surgery, hepatology and a well-established nurse endoscopist team. In addition to gastrointestinal endoscopy, the unit also performs; bronchoscopy, endoscopic
ultrasound (EUS) and ERCP. The multidisciplinary team delivering endoscopy allows for the flexible cover of available capacity, ensuring capacity is maximised.

Is the service safe?

Mandatory training

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Queen Elizabeth Hospital

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
</tr>
<tr>
<td></td>
<td>staff trained</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Corporate induction</td>
<td>96</td>
</tr>
<tr>
<td>Major incident planning</td>
<td>785</td>
</tr>
<tr>
<td>Infection control</td>
<td>738</td>
</tr>
<tr>
<td>Fire training</td>
<td>745</td>
</tr>
<tr>
<td>Information governance</td>
<td>741</td>
</tr>
<tr>
<td>Manual handling</td>
<td>528</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>454</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall training compliance rate of 94.2% for qualified nursing staff. The trust’s training targets were met for five of the seven mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in medicine at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
</tr>
<tr>
<td></td>
<td>staff trained</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Major incident planning</td>
<td>399</td>
</tr>
<tr>
<td>Information governance</td>
<td>345</td>
</tr>
<tr>
<td>Fire training</td>
<td>339</td>
</tr>
<tr>
<td>Infection control</td>
<td>337</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>122</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall training compliance rate of 88.4% for medical staff. The trust’s training targets were met for one of the five mandatory training modules for which medical staff were eligible, though all modules had a completion rate of over 80%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Ward managers and administrators used an electronic workforce dashboard to monitor, plan and record mandatory training for their team. This meant managers could identify in advance when an individual’s training was about to expire and arrange for a refresher course. The
system enabled managers to identify trends, such as when a topic had expired for a number of staff at the same time. Training was organised to fit into existing rostas, which meant ward managers could schedule protected training time for ward staff in advance without leaving the ward short-staffed.

Divisional leadership teams reviewed mandatory training completion as a standing agenda item at monthly meetings to ensure continual progress and to address any trends in expired modules.

Staff spoke positively about access to mandatory training and could articulate how this benefited their practice and professional development.

**Safeguarding**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Though the trust has reported figures for safeguarding level 1 training, it should be noted that the trust has not designated this as mandatory training.

**Queen Elizabeth Hospital**

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1</td>
<td>785</td>
</tr>
<tr>
<td>Safeguarding level 2/ DOLs and mental capacity</td>
<td>642</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall safeguarding training compliance rate of 96.5% for qualified nursing staff. The trust’s 90% completion target was met for both of the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in medicine at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 1</td>
<td>399</td>
</tr>
<tr>
<td>Safeguarding Level 2/ DOLs and Mental Capacity</td>
<td>106</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall safeguarding training compliance rate of 92.3% for medical staff. The trust’s 90% completion target was met for one of the safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Following the publication of the 2018 Intercollegiate Document on level 2 safeguarding training for the Healthcare Practitioner Induction Programme for all qualified staff commencing employment, the trust evaluated safeguarding training provision and enhanced this to level 3. In October 2018 100% of required staff had up to date safeguarding level 1 training, and 95% of required staff for each of safeguarding levels 2 and 3 had up to date training.

We saw good examples of safeguarding awareness, including fast actions to prevent avoidable harm. For example, a healthcare assistant (HCA) raised a safeguarding concern to a senior member of their team when they were concerned about the relationship between a patient and a family member. The site safeguarding team responded rapidly and worked with the local authority safeguarding team to work towards a solution. This reflected the confidence all staff demonstrated, regardless of role or seniority, in safeguarding responsibilities.

Nurses in the ambulatory care unit demonstrated advanced safeguarding procedures commensurate with a unit that saw a high volume of patients without the presence of a medical team. The team discussed social and home situations with each patient on admission and ensured discussions were held with relatives present only when staff were assured of the nature of a relationship. This reflected learning from an incident in which a patient disclosed domestic abuse to a member of staff, who escalated the situation appropriately.

The teams on Bourneville and Harborne wards provided care for patients with complex needs, including those with multiple morbidities and significant social care challenges. Staff demonstrated a detailed awareness of the signs of neglect, abuse and self-harm risks and used established escalation pathways to obtain specialist support, including urgent support.

The safeguarding team maintained oversight of all referrals and tracked these for completeness, appropriate escalation and the quality of documentation in line with the principles of making safeguarding personal. The team worked with the community safeguarding team to coordinate care and carried out reviews with ward teams to ensure appropriate care was delivered. The trust safeguarding group carried out a random sample of safeguarding cases each month and assessed them for compliance with trust policies and areas for improvement. We reviewed the 11 safeguarding referrals made by the team on ward 411 from April 2018 to October 2018. In each case staff had escalated and documented concerns appropriately and there was extensive involvement of multidisciplinary colleagues and specialist services. Staff demonstrably placed patients’ wellbeing and safety at the centre of their actions and worked with them to understand complex family and social situations, including when this presented risks to the patient from outside of the UK.

All wards had dedicated safeguarding link nurses who attended study days with the safeguarding team and acted as expert liaisons for their colleagues. We spoke with two link nurses on ward 518 who demonstrated a detailed knowledge of the safeguarding challenges on the ward and were confident and trained to address them.

Allied health professionals (AHPs) took on safeguarding link roles and had undertaken training to be able to make their own referrals. Staff had delivered specialist training on human trafficking and domestic violence to colleagues across the hospital.

**Cleanliness, infection control and hygiene**

Staff in the inpatient endoscopy unit followed decontamination standards set by the Joint Advisory Group on GI Endoscopy (JAG) and had appropriate facilities for the storage and decontamination of equipment.

Ward housekeepers took a lead role in infection prevention and control standards and audits. For example, the infection control team had trained a housekeeper on ward West 2 to carry out
monthly hand hygiene and infection control audits. The housekeeper on ward 313 displayed monthly audit results, including highlights of good practice and areas for improvement. The infection control team maintained oversight of the local audits to identify trends and areas for improvement.

Staff adhered to good hand hygiene practice during most of our inspection although there were opportunities for improvements in some areas. For example, during a ward round on ward 313, the consultant and junior doctor met nine out of 11 opportunities for hand hygiene.

The infection control team presented audit results and learning during monthly preventing harm meetings. The team briefed staff across divisions on outbreaks affecting the local population, such as measles, and reminded them of treatment protocols for conditions they might rarely see. The team also used group meetings as an opportunity to further improve staff knowledge of high impact interventions and antimicrobial prescribing.

The hospital participated in the national serious infection commissioning for quality and innovation CQUIN and monitored antimicrobial prescribing and in 2018/19 the hospital reduced average consumption use by 2%.

In their October 2018 ward newsletter, the ward 625 team dedicated space to highlight infection prevention and control. This included a review of norovirus outbreaks and the identification of areas for improvement. The team increased efforts to educate patients on the importance of washing their hands regularly and the ward manager empowered the team to challenge visitors who did not adhere to good hand hygiene standards, including colleagues from other clinical areas.

The trust monitored hand hygiene results at divisional level and from April 2018 to September 2018 compliance was 93%. This was an overall average figure and reflected divisional-level averages from 85% in division C to 94% in division A. Ward 625 improved hand hygiene compliance by 65%, to 84% in July 2018, following a period of poor performance earlier in the year.

Inpatient wards performed consistently well in the cleanliness element of the annual patient-led assessment of the care environment (PLACE). In 2018 medical care scored over 99%, which reflected five consecutive years of performance above the national average.

Senior nurses and infection control nurses used monthly exception reports to identify areas for improved practice and to document how these were addressed through work with specialist and service teams. For example, in June 2018 the infection control team provided more detailed guidance to nurses on Edgbaston ward for catheter care and worked with housekeeping teams to establish more consistent practice in relation to high and low-level dust.

**Environment and equipment**

Each ward had a dedicated storage area for equipment and we saw staff adhered to good storage and tidiness principles to avoid obstructing fire escape routes. All the 63 items of equipment we checked was labelled with an up to date electrical safety test sticker and information for staff on who was responsible for equipment maintenance.

In most areas staff stored chemicals and hazardous substances in line with the Control of Substances Hazardous to Health Regulations (2002). However, on ward West 2 we found a storage cupboard unlocked with chemical cleaning products readily accessible and oxygen stored inappropriately. We spoke with the nurse in charge about this who resolved the situation.

The discharge suite had space for 17 chairs and eight bed spaces in two bed bays and two side
rooms, which provided dedicated accommodation for patients with infection control needs.

The ambulatory care unit provided care for patients using 24 beds and 57 trollies.

Each ward or clinical area had a resuscitation trolley with emergency equipment and medicines. For each trolley we looked at staff had documented daily safety checks and medicines were secured with tamper-proof seals. In some wards, such as ward 516, the resuscitation trolley was stored under a cover that discouraged staff from the temptation to use equipment from it in a non-emergency situation. However, trollies were not routinely locked, which meant staff could not be assured that all equipment was in situ and had not been removed or tampered with.

The resuscitation team had not maintained the trust policy of quarterly resuscitation equipment safety checks due to a lack of capacity in the team, which meant there was limited assurance of continual oversight. For example, a June 2018 check of the resuscitation equipment in therapies suites found multiple items of expected equipment were missing, including from the trolley in the gym that had been provided following an incident. There was no documented evidence of a further check on this equipment as of October 2018. The audit template included monitoring of how many times staff documented daily safety checks. However, this was not consistently completed and it was not evidence the resuscitation team took action for poor performance. For example, the audit forward West 2 in July 2018 noted staff had not documented daily checks for each day in the previous three months but the report stated that there were no issues with the resuscitation trolley. From April 2018 to July 2018 nine medical inpatient wards had not undergone a resuscitation equipment audit.

The tissue viability team (TVT) carried out an annual audit of foam mattresses alongside the infection control team to ensure they were fit for purpose and provided pressure reduction. The team used this audit to complement the checks ward-based staff carried out on mattresses after each patient was transferred or discharged. The TVT established audit teams that included tissue viability nurses and ward-based staff such as nurses, healthcare assistants (HCAs) and housekeepers. This ensured the audit team was multidisciplinary and included staff who were accustomed to using the equipment. The most recent audit took place in June 2018 and in division C 36% of mattresses failed the audit. This included infection control failures such as breaches of the protective covers and reflected an improvement on the previous annual audit. The audit team made four recommendations to increase the rate of improvement and reduce the cost of replacement mattresses and covers through more frequent and thorough checks between patients.

A tissue viability nurse carried out six monthly equipment quality audits on inpatient wards to identify training needs amongst nurses in the operation of air mattresses. The team identified mattresses that regularly alarmed and worked with clinical staff to implement prevention strategies and more consistent usage.

Each ward had a standardised cannulation trolley with restricted access. The trolley contents and layout was the same on each ward, which helped on-call clinical staff during emergencies.

In all areas we checked sharps were stored, handled and disposed of in line with the Health and Safety Executive Sharps Instruments in Healthcare Regulations 2013, such as properly assembled and labelled sharps disposal containers. However, it was common practice to leave temporary lid closures open. This was the case in 14 of the 20 sharps bins we looked at, including sharps bins stored in open areas of wards, and presented a risk that children or those with limited capacity would injure themselves.

The inpatient therapies gym was equipped with sprung wooden floors to reduce the impact and risk of injury if patients fell. All therapies areas included examination bays that were visible to staff from a central point, including exercise areas used for classes.
Medical care services performed significantly better than the national average in the PLACE annual assessment measure for the condition, appearance and maintenance of the environment. In 2018 the hospital scored over 99%, which was 5% better than the national average and reflected five consecutive years of above-average performance.

**Assessing and responding to patient risk**

Senior nurses led a hospital at night team, which provided on-demand support to ward teams when patients deteriorated or needed a clinical review from more senior staff. An out of hours medical emergency response team and 24-hour critical care outreach team (CCOT) also provided support to deteriorating or acutely unwell patients out of hours.

Staff on each ward used the standardised early warning scores (SEWS) system to assess patients for deterioration using an electronic patient records and tracking system. The system enabled multidisciplinary teams across the hospital to identify and respond to deteriorating patients. For example, CCOT provided a 24-hour, seven-day service to all wards and responded to patients who triggered specific SEWS scores on the system. The hospital at night, out of hours medical team and CCOT had access to this and the system alerted them when a patient needed urgent review.

We looked at a sample of 28 SEWS and sepsis screening records in seven of the wards we included in our inspection. In each case staff had taken appropriate action and liaised with clinicians or response teams.

Staff used a sepsis screening tool based on the national Sepsis 6 standard, which included electronic monitoring of the time it took to prescribe antibiotics when sepsis was confirmed. Nurses undertook additional training to act as sepsis links on their wards and worked with matrons, the practice development team and sepsis leads to ensure consistent practice.

The quality and outcomes research unit monitored key SEWS outcomes using a monthly audit of electronic data. This measured the percentage of patients with a SEWS score above the threshold of six who staff escalated within 30 minutes, based on a target measure of 90%. From January 2018 to September 2018 staff escalated an average of 86% of patients within 30 minutes, reflecting a monthly range from 82% to 89%. This meant medical care services did not meet the target escalation rate in any month in this period.

Staff had the option to complete university modules in the management of deteriorating patients. Staff who worked across the hospital, such as the lead outlier nurse, had completed this to help them provide care for patients with multiple needs from different medical specialties. This helped to increase support to ward-based staff, who used the SEWS to monitor patients.

Clinical Educators (CEs) worked with the resuscitation team to deliver an acute illness management (AIMS) course focused on recognition of the deteriorating patient. The training included simulation exercises, role plays and formal assessment. This was a hospital-wide initiative designed to improve the response of ward-based teams to patients with elevating SEWS scores and to help them recognise early signs of deterioration.

Staff on Edgbaston ward, a ward for patients who were self-funding care or whose care was paid for by an insurance company, assessed patient’s clinical needs prior to admission. This ensured they could provide safe care with the equipment available to them and the skill mix of staff. For example, the team was usually unable to accept patients with a tracheostomy and instead worked with colleagues across the hospital to identify a more appropriate location for their care.
Wards were secure with restricted access, which prevented unauthorised people from accessing clinical areas. This helped staff to protect patients from avoidable harm, such as in safeguarding situations. However, it also meant in some areas there was an additional challenge in facilitating access for the emergency on-call resuscitation team (crash team). For example, staff on Edgbaston ward said the crash team did not have the code needed to open the doors into the unit. This had meant during a recent emergency that a member of the ward team had to be used to keep the doors open for the crash team’s arrival, rather than support the clinical team with the patient.

At least three handovers took place daily on each ward; one each for nurses, AHPs and junior doctors. Staff from each team routinely joined other handovers where this would benefit patients through more coordinated assessment of risk.

Nurses in the cardiac catheter laboratory who cared for patients who underwent conscious sedation procedures had advanced life support (ALS) training. However, the team was not compliant with Royal College of Anaesthetists guidance that the nurse responsible for monitoring the patient only be responsible for that task as nurses were required to carry out multiple duties as well as monitoring the patient.

Nurses led care on the ambulatory care unit and there were no medical staff permanently based there. Patients cared for were medically stable and nurses had access to immediate medical escalation on inpatient wards in the event a patient became unwell.

Emergency tracheostomy boxes were located on each ward that cared for patients with this procedure and a standard operating procedure for the safe use of equipment was available at each patient’s bedside.

A fire risk assessor carried out an annual risk assessment of each clinical area or ward to assess compliance with trust policy and the following national legislation: The Regulatory Reform (Fire Safety) Order 2005, The Health and Safety (Safety Signs and Signals) Regulations 1996 and the Dangerous Substances and Explosive Atmosphere Regulations 2002. We reviewed a sample of five of the most recent fire risk assessments for medical inpatient areas, which had taken place in April 2018. The assessments highlighted that ward-based staff were not trained to use fire extinguishers, which presented a risk that untrained people who tried to use a fire extinguisher would be injured. The risk assessor noted security staff would be the first staff group with training to respond to an alarm. All staff had training in evacuation procedures relevant to their usual area of work. In most cases where the fire safety assessor identified area for improvement, there was evidence ward managers acted. For example, fire risk assessments in Bournville ward, Harborne ward and wards 515 and 516 found areas for improvement in relation to the maintenance of fire doors and other fixtures. Ward managers had ensured all areas were rectified within the time scale prescribed. However, in the discharge lounge, there had been no documented action taken with regards to a fire door with a failed smoke seal. In the therapies south suite, the fire risk assessor identified the tendency for staff to wedge open automatic fire doors. This was documented in an April 2018 fire risk assessment. Although this risk was documented as resolved, we found automatic fire doors in this area were frequently wedged open during our inspection.

Procedures were in place for therapists to follow when medical patients became unwell when using the inpatient gyms. Each patient was transferred to the gym with their medical notes, which acted as a safety system as on-call doctors could quickly review patients if they were called to the gym to review a patient.

A microbiology pharmacist and an infection control senior nurse led sepsis services and each ward or clinical department had local sepsis leads. A monthly working group of clinicians from
multiple specialist services and across divisions took place as part of a sepsis CQUIN to ensure standards of monitoring and treatment were consistent.

Staff in the endoscopy unit had developed local safety standards for invasive procedures (LocSSIPs) in line with NHS Improvement guidance. The team had combined these with World Health Organisation (WHO) surgical safety checklists to implement safety and care plans for procedures such as bronchoscopy, lower gastrointestinal procedures and percutaneous endoscopic gastronomy (PEG) insertion. This meant invasive procedures were carried in line with national and international safety guidance.

**Nurse staffing**

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in medicine.

The overall fill rate for qualified nursing staff dropped from 85.6% in March 2018 to 79.4% in June 2018 with Good Hope Hospital having the lowest fill rates for both time periods.

The staffing data for June 2018 for Queen Elizabeth hospital shows a drop of around 900 members of qualified nursing and midwifery staff. This has been queried with the trust.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>919.5</td>
<td>966.8</td>
</tr>
<tr>
<td>Community locations</td>
<td>39.4</td>
<td>41.7</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>517.0</td>
<td>631.7</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>192.2</td>
<td>235.4</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>266.0</td>
<td>384.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

We established local nursing vacancy rates in a sample of inpatient wards and medical services during our inspection and found these varied widely. There were five whole time equivalent (WTE) nurse vacancies in the pain team and on ward 313. Ward 516 had the most nursing vacancies with a need for 12 WTE nurses to meet the establishment figure. Wards 411 and 514 had successfully recruited to vacant roles, which would mean both wards were fully staffed by the end of 2018.

Short staffing in some wards was commonplace, such as on ward 313 where staff said they routinely worked with four nurses instead of six and three HCAs instead of four. Staff on most wards said nurse shortages was the most stressful part of their job and senior nurses said it was their biggest challenge. On ward 518 staff told us they were always short staffed and regularly
relied on agency nurses.

Division C, which included a large number of inpatient medical services, had implemented a rolling programme of continuous nurse recruitment to address on-going shortages. This involved a three-monthly recruitment advertisement drive with weekly shortlists and two-weekly interview schedules that senior staff offered flexibly around applicants. This helped to maximise the number of potential new nurses that could be interviewed. The division had introduced more flexible working options that staff could choose in advance, as a strategy to improve recruitment.

From April 2017 to March 2018, the trust reported a turnover rate of 9.7% for qualified nursing staff in medicine. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:
- Queen Elizabeth Hospital: 4.2%
- Birmingham Heartlands Hospital: 14.9%
- Good Hope Hospital: 15.5%
- Solihull Hospital: 16.6%
- Community locations: 13.2%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

In addition to the work carried out by the human resources team, ward managers monitored the reasons staff gave for leaving. This helped local leadership teams to identify challenges faced by the workforce and implement strategies to address them. This process indicated high levels of staff satisfaction in some areas. For example, the ward manager on ward 514 found all staff who had left in the previous 12 months had done so to take up promotion or developmental posts. All of the senior staff nurses on this ward had joined as staff nurses and achieved promotion internally.

From April 2017 to March 2018, the trust reported a sickness rate of 4.7% for qualified nursing staff in medicine. This is above the trust targets of 3.6% for Queen Elizabeth Hospital and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

- Queen Elizabeth Hospital: 4.5%
- Birmingham Heartlands Hospital: 5.4%
- Good Hope Hospital: 4.2%
- Solihull Hospital: 4.7%
- Community locations: 2.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Senior staff on ward 621, an oncology ward, said staff stress and sickness was their main worry. They said the closure of two local oncology wards had added pressure to the service and that the complexity of patient needs meant nurses often worked beyond their scheduled hours and under sustained stress. The ward manager used phased bed closures, enhanced overtime and more flexible working to try and address this but staff we spoke with said the cumulative stress meant they were more likely to experience sickness.

From April 2017 to March 2018 the trust reported 13,503 shifts were filled by agency staff, 70,581 by bank staff and 40,565 shifts were left unfilled.
A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>3,090</td>
<td>53,472</td>
<td>31,820</td>
</tr>
<tr>
<td>Other sites</td>
<td>10,413</td>
<td>17,109</td>
<td>8,745</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The pain team was vulnerable to short staffing and could not use agency or bank staff for maternity leave or to cover sickness. The team had no dedicated administration support and nurses were required to carry out administrative responsibilities in addition to their clinical role.

Staff on ward 625 had piloted and implemented new processes to replace the traditional nurse handover. The new processes involved a whole-team board handover followed by a nurse-led patient-focused review at each patient’s bedside. Staff had developed each process to adhere to specific checklists that acted as assurance of up to date risk assessments and observation intervals and reflected a significant improvement in the ability of nurses to lead safe care.

We observed a nurse handover on ward 518 and found it was delivered as an interactive learning and development session, with nurses reviewing each patient in depth and identifying any missed activity.

**Medical staffing**

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in medicine.

The overall fill rate was similar for the two time periods for the trust as a whole (89.2% in March 2018 and 92.7% in June 2018) and for the majority of the sites. However, the staffing data for June 2018 for Queen Elizabeth hospital shows a rise of around 700 members of medical staff. This has been queried with the trust.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>317.2</td>
<td>321.8</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>225.0</td>
<td>251.5</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>75.3</td>
<td>110.8</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>62.6</td>
<td>78.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From April 2017 to March 2018, the trust reported a turnover rate of 4.2% for medical staff in medicine. This is below the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope
Hospital, Solihull Hospital and community locations.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 2.3%
- Birmingham Heartlands Hospital: 11.1%
- Good Hope Hospital: 12.4%
- Solihull Hospital: 10.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From April 2017 to March 2018, the trust reported a sickness rate of 0.8% for medical staff in medicine. This is below the trust targets of 3.6% for Queen Elizabeth Hospital and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

A breakdown by site is below:

- Queen Elizabeth Hospital: 0.8%
- Birmingham Heartlands Hospital: 0.6%
- Good Hope Hospital: 0.7%
- Solihull Hospital: 1.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From April 2017 to March 2018 the trust reported that 15,816 shifts were filled by locum medical staff, 7,741 by bank medical staff and that 3,125 were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Locum</th>
<th>Bank</th>
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</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>4,959</td>
<td>2,574</td>
<td>752</td>
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<tr>
<td>Birmingham Heartlands Hospital</td>
<td>3,707</td>
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<tr>
<td>Solihull Hospital</td>
<td>887</td>
<td>1,116</td>
<td>136</td>
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(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In May 2018, the proportion of consultant staff and junior (foundation year 1-2) reported to be working at the trust was similar to the England average.

Staffing skill mix for the 732 whole time equivalent staff working in medicine at University Hospitals Birmingham NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
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<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>30%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>21%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Overnight and at weekends one specialist registrar (SpR), two senior house officers (SHOs) and two foundation year 1 (FY1) doctors provided ward cover. A second SpR worked between the wards and the clinical decision unit (CDU). Additional doctors provided cover in individual specialties including renal, respiratory, liver medicine, hepatology and cardiology.

Military doctors routinely worked in the hospital and provided care and treatment in line with the remit of the Royal College of Defence Medicine.

Hospital-based consultants and junior doctors provided care on Edgbaston ward, a ward for private patients. Nurses told us doctors were responsive when they requested support or a patient review.

A dedicated consultant maintained oversight of care on ward 517, a ward recently established for acute short-stay patients. They reviewed patients daily and provided weekend cover twice per month to facilitate weekend discharges.

Medical staff worked on a team-based system that meant consultants led their own team of junior doctors and patient list. Patients were allocated to consultants at the point of admission on the ward, which meant medical teams could balance clinical specialties with workload. S

Medical care services carried out annual audits against NHS Services Seven Days a Week Forum's seven-day services priority standards. The most recent audit results were published in June 2018 and indicated 74% compliance against the standard that each patient should have a consultant review within 14 hours of admission. This result demonstrated continual improvement, from 65% in June 2017 and 51% in September 2016. This was an overall figure and reflected 78% compliance on weekdays and 63% compliance at weekends.

**Records**

Staff used an electronic, bespoke prescribing information and communications systems (PICS) to document care and observations including risk assessments. The system enabled clinical staff to review patients' test results and diagnostics remotely and provided a high degree of assurance when patients were transferred between wards.

The electronic records system did not have the function to accurately identify why patient observations may not have been recorded. For example, if a patient refused to have their observations take or was off the ward undergoing scans, PICS recorded this as a missed observation and generated an incident report.

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* Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

**Source:** NHS Digital - Workforce Statistics - Medical (01/05/2018 - 31/05/2018)
In four sets of patient notes on the stroke wards staff had completed risk assessments and baseline observations according to trust policy and national standards. This included timely review by the stroke consultant, documented thrombolysis and speech and language therapy input within eight hours. On ward 313 staff had completed appropriate risk assessments for each of the four patients whose notes we reviewed, including detailed skin integrity documentation for a patient at risk of pressure sores.

Staff in the discharge suite said it was a regular occurrence for patients to arrive without medical notes available or completed. This meant the team spent additional time liaising with colleagues across the hospital to ensure they could facilitate an effective discharge.

The clinical risk and compliance unit and CEs carried out a rolling programme of nursing documentation audits, which included a sample of 10 records on each ward. The audit assessed the completion of records against 54 standards and against the trust’s minimum 80% compliance standard. The results were highly variable and ranged from 29% for the documentation of lying and standing blood pressure to 99% for the recording of the date in the daily care record. In ten areas wards scored less than 50%, which was the threshold for the audit team to require immediate action. Each ward manager received individual results for their area and was responsible for implementing improvements.

**Medicines**

A pharmacy team was dedicated to each ward and carried out daily scheduled visits and ten clinical pharmacy technicians were in post for medical care services. This team supported medicines management practices and meant patients awaiting to take away (TTO) medicines received this in a timely manner.

Senior staff in some areas had identified an unusual trend of missed doses as a theme in incident reporting. They carried out a series of root cause analyses and identified that between 70% and 80% of missed doses were patient refusals but the electronic documentation system did not have the function to identify this. This meant instances in which patients refused their medicine, or who could not take it because they were undergoing a procedure, were flagged as missed doses.

Clinical teams worked with IT and the antimicrobial pharmacy team to develop solutions to this issue once it was clear patients had not been at risk.

Senior ward staff used an established process to address medicine errors. This included a multidisciplinary approach to training and education with input from the ward manager, ward pharmacist, AHPs and CEs. Where a member of staff was involved in a medicine error, they subsequently undertook supervised practice, an accountability discussion and practical reassessment. This process helped to identify gaps in knowledge while supporting staff to maintain their usual standard of safe work.

The chief pharmacist and patient safety and non-medical prescriber (NMP) pharmacist led a quarterly patient safety group controlled drugs (CDs) audit to identify levels of safety compliance against the trust 85% standard, including compliance with Misuse of Drugs Act. In March 2018 all wards except ward 513 and Bournville ward achieved the minimum standard. In July 2018 wards 302, 514, 515, 516 and 517 did not reach the minimum standard with an average 78% compliance between them.

The pharmacy and medicines safety teams carried out monthly audits of medicines management in each ward or clinic area to establish standards against 42 safety and quality criteria. In September 2018 and October 2018 overall compliance in medical care areas was 87%. This reflected a range from 68% compliance in wards 302 and 411 to 100% compliance in wards 622 and 623 and the discharge lounge. In this audit 50% of wards met the trust’s minimum standard of
90% compliance. The chief pharmacist highlighted areas of ongoing challenge in their annual audit report of the safe and secure handling of medicines and the lead nurse for medicines management worked with them to implement ward-specific action plans.

Staff did not always act on fridge temperatures that exceeded the safe storage range for medicines. For example, on one day of our inspection a medicines fridge on Bournville ward was running three degrees higher than the manufacturer’s maximum limit. Staff had documented this but not taken action and continued to use medicine from it. On ward 303 two medicines fridges had exceeded the maximum guide temperature on a combined total of 25 occasions in the previous 10 weeks. Similarly, staff on ward 517 had not taken action when a fridge exceeded the temperature limit on two occasions.

The safe storage of medicines was highly variable across medical services and we found several areas for attention. For example, the room used to store intravenous fluids on Bournville ward and the clinical room on ward 515 were unlocked. This presented a risk of unauthorised access. Medicines trollies on wards 303 and 513 and Bournville ward were congested, overstocked and disorganised and contained loose medicines in foil wrappers. On wards 513, 514 and 517 potassium infusions were not separated.

On ward 515 a temperature checklist for one medicines fridge did not have the month recorded and the nurse in charge said they had discarded all previous records. On ward 517 four bottles of antibiotic syrup had expired and staff were unsure how to dispose of the stock. Nurses on this ward did not know how to reset the maximum and minimum temperature monitoring system on the fridge despite a suspicion it had provided erroneous readings. On ward 515, there were unlabelled medicines in a patient’s personal medicine storage locker. This meant staff could not be assured the medicines were for the person being cared for. In three medicines fridges air circulation was compromised by overstocking or use of items such as trays and plastic bags. Overall these issues meant staff did not have assurance that medicines management processes were safe and in line with trust policy.

The division C preventing harm group identified on-going issues with the consistency of temperature recording of medicine fridges and identification and disposal of expired medicines. This was consistent with our findings but we could not identify why this had not resulted in improvements towards consistent standards.

The antimicrobial stewardship and sepsis group worked to a wide-ranging action plan to achieve a range of improvements in training and information access for staff. This included the addition of antimicrobial stewardship training to the infection control mandatory training module for doctors, the modification of PICS to include sepsis screening and improved monitoring of antibiotic usage data.

We looked at the medicines charts of 11 patients receiving antibiotics. The standard of documentation was good in nine cases and in two cases there was missing information on the indication of the medicine. We received conflicting information from pharmacy technicians and nurses about this as they were unsure as to whether this was the pharmacist’s responsibility or the prescribing doctor’s responsibility.

**Incidents**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
From August 2017 to July 2018, the trust reported no incidents classified as a never event for medicine.

(Source: Strategic Executive Information System (STEIS))

Staff in the cardiac catheter lab described how procedures had changed and safety improved following a never event prior to August 2017. This involved a retained swab during a pacemaker procedure. As a result of the never event, the senior divisional team implemented more advanced training, a documented swab count process and sourced larger gauze that was easier to see.

In accordance with the Serious Incident Framework 2015, the trust reported 78 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2017 to July 2018.

The breakdown by type of incident reported were:
- Slips/trips/falls 36 (45.6% of total incidents)
- HCAI/Infection control incident 32 (41.0% of total incidents)
- Pressure ulcer six (7.7% of total incidents)
- Treatment delay two (2.6% of total incidents)
- Surgical/invasive procedure one (1.3% of total incidents)
- Medication incident one (1.3% of total incidents)

Site specific information can be found below:
- Queen Elizabeth Hospital (August 2017 to July 2018): 60 incidents
- Good Hope Hospital (April to July 2018): 11 incidents
- Birmingham Heartlands Hospital (April to July 2018): five incidents
- Solihull Hospital (April to July 2018): two incidents

(Source: Strategic Executive Information System (STEIS))

Senior staff responsible for investigating incidents invited colleagues involved to take part in the root cause analysis (RCA), which was a supportive approach to understanding an event. Senior teams had worked to demystify incident investigation processes amongst ward staff using more open communication and establishing nurse-led working groups to support the investigator. Consultants invited more staff to attend morbidity and mortality meetings as part of the increased involvement of different staff groups, which helped establish a whole-team approach to preventing and managing incidents.

From April 2018 to June 2018 staff reported 15 incidents relating to diabetes, two of which
resulted in minor harm. This was a division C figure and included incidents in the CDU, therapies services and outpatients. A nurse consultant in diabetes led a ‘back to the floor’ education programme as a result of learning from incident investigations. This included practical guidance and training of nurses and medical staff on the administration of insulin, the management of specific diabetic complications and care for patients who were prescribed steroids.

Following a serious incident that involved a patient suffering a fractured neck of femur, the team on ward 411 carried out a root cause analysis and communicated learning from the incident widely. For example, the senior team reinforced a requirement for nurses to carry out lying and standing blood pressure (BP) checks for each patient on admission. The PDN team delivered practical training on effective BP checks to support this improvement in practice.

PDN team leaders monitored incident reports across their whole division to identify gaps in education and learning and opportunities for improvement. For example, the team acted on a trend of falls to implement more advanced moving and handling training that included practice on safely scooping patients from the floor.

AHPs had updated standard operating procedures for the inpatient therapies gym as learning from an incident in which a patient had died. They worked with the doctors who responded to the emergency and identified a need for faster access to key medical equipment. As a result, the therapies team displayed emergency contact numbers to secure portable echocardiogram (ECG) and x-rays next to each telephone and obtained drip stands and a BM machine to keep in the gym. The team worked to a new standard that two resuscitation trollies would be brought to each emergency. AHPs also developed more advanced guidance for safe procedures to follow in the event a patient became unwell whilst using equipment, including guidance on using a plinth. The review of safety procedures that resulted from the incident also highlighted that standard hospital beds would not fit through the door to the activities of daily living (ADL) suite, which could prevent staff from extricating a patient in an emergency. To address this, they worked with the moving and handling and CDU teams and established an agreement to obtain rapid access to a trolley in an emergency. The team also piloted the use of an air lift device and planned to obtain this permanently after positive results.

Medical specialties used quality management meetings to review incidents and identify opportunities for learning. For example, the team on ward 625 implemented new checks to ensure they weighed patients at appropriate intervals. The senior team for this ward established improved communication standards for clinicians when patients were treated by multiple services following an incident of potential cross-infection when staff did not act on test results from another hospital.

The risk and audit officer prepared incident reports for the geriatric medicine team on a quarterly basis. From July 2017 to June 2018 staff in this specialty reported 2597 incidents, of which 97% were classified as resulting in minor impact and 2% were classified as insignificant. The remaining 1% of incidents were moderate or severe, with no incidents resulting in a patient death. There were five incident themes and 39% of incidents related to a failure to follow trust standards of care, such as if staff did not complete observations at scheduled times. Other themes were patient falls, pressure ulcers and staffing issues. Consultants reviewed such outcomes during monthly meetings and there was evidence of practice and policy reviews as a result, including in the review of case mix and seniority levels of doctors.

The clinical centre for haematology (CCH) took action to change practices following learning from incidents. For example, the team implemented a new standard operating procedure for the threshold to escalate care to the 999 service if a patient became acutely unwell and the team could not obtain rapid medical support. This was a theme for incidents reported in July 2018 in the service. In one incident a patient deteriorated over the course of over eight hours waiting for treatment escalation. There was a failure to assess the patient’s resuscitation status and staff had to call 999 for an ambulance transfer. Another incident related to a failure of the on-call
overnight medical team to review an acutely unwell patient on ward 625 despite prescribing them antibiotics. The quality development lead, the lead nurse for quality and clinical standards and the clinical business development lead investigated such incidents and implemented action plans.

We reviewed four SI reports for incidents that occurred in medicine from April 2018 to October 2018. In each case an appropriate range of staff had contributed to the investigation, which was methodical, detailed and included input from every medical speciality that had seen the patient. There was evidence of consistent compliance with duty of candour requirements, including efforts to speak with the next of kin of deceased patients. In each case the outcomes of serious incidents led to improved practice, which reduced the risk of recurrence. For example, one SI found a lack of clarity about which specialty should look after patients with chronic liver disease. The action plan for the incident resulted in clearer lines of accountability when patients are treated by multiple specialties. Another SI investigation related to an avoidable level 3 pressure ulcer and found multiple failures contributed to this, including inaccurate waterlow calculation and delays in recognising that a change of pressure-relieving equipment was necessary. Learning from other SIs resulted in more stringent checks by ward teams of risk assessments completed within trust standard timeframes when patients were admitted from the emergency department or CDU.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services as all incidents were reported under the core service ‘Other’.

*(Source: NHS Digital - Safety Thermometer)*

After our inspection we asked the trust to provide the above data. From April 2018 to October 2018 medical care services reported 17 hospital-acquired pressure ulcers and 91 falls, 13 of which resulted in harm.

Falls were a theme of incident reports, including those reported through STEIS. The AHP team had a key role in falls prevention and where a cluster of falls had happened, such as on a ward, they worked with the ward team to identify contributing factors. For example, the team had focused on mealtimes as a time of day when falls were more commonly reported and looked at whether patients had relatives visiting and whether an in increase in the number of staff to help with meals would reduce the prevalence of falls. Ward teams developed solutions to falls risks based on trends in their clinical areas. For example, the team on ward 513 carried out a mini RCA immediately after each fall. This enabled the team to identify contributing factors and what was happening immediately beforehand. Through this process the team identified the need to get to know patients, including their habits and preferences, as a strategy to identify risk factors. The lead falls nurse and practice development team had completed work across medical wards to help staff implement strategies to reduce falls risks, such as providing non-slip socks and carrying out more effective bed rails assessments.

Unwitnessed falls were a recurring theme in incident reports and ward staff identified this was an increased risk where patients were accommodated in a side room. This was because nurses
could not constantly observe patients in different side rooms. To reduce the risk ward managers implemented a cohort system that meant patients with similar risks were accommodated in a shared bed bay. This meant staff could keep a closer watch on more patients at the same time and implement falls prevention strategies in each area. The team on ward 517 had carried out falls work to adapt the environment to patients with increased risk, such as providing non-slip socks and increased nurse supervision. The team had produced a falls newsletter to help provided guidance and education to colleagues around the hospital on effective falls prevention.

Each ward displayed the outcomes of their most recent patient safety audits, such as urinary catheter infections and IV cannula insertion and care. However, systems were not in place to monitor the frequency of the audits and on ward 313 information on display related to December 2017, 10 months prior to our inspection.

The tissue viability team carried out pressure ulcer and wound prevalence audits through the NHS Safety Thermometer every month and carried out a comprehensive review every two years. They presented this data to divisional and trust preventing harm boards and worked with link nurses through study days to improve performance.

The falls team and health and safety team had carried out a substantial programme of work to improve staff knowledge of and practice in falls prevention. This included enhanced training programmes, practical ad-hoc coaching in real time with patients and the completion of slips and trips inspections. The health and safety advisor identified that healthy and safety issues contributed to 66% of falls and that mobile equipment without brakes contributed to 20% and a failure to delivered enhanced care a further 20%. The project teams used this information to tailor training and guidance.

### Is the service effective?

#### Evidence-based care and treatment

The trust had a standard that all policies should be reviewed annually or whenever the national or international guidance on which they were based changed. Divisional teams monitored this through governance review processes and clinical leads provided a review of instances where trust policy could not be updated. In September 2018 division A met 75% of applicable National Institute of Health and Care Excellence (NICE) guidelines

Clinical services pursued recognition, accreditation and peer review as part of benchmarking and quality processes by national and international professional bodies as evidence of the standards of their practice and patient outcomes. Seven such reviews took place from April 2018 to October 2018. The inpatient endoscopy unit had been accredited by the Royal College of Physicians (RCP) Joint Advisory Group (JAG) on GI Endoscopy. The RCP had inspected the service in August 2017 and noted 14 areas of excellence, including training opportunities for junior doctors and responsiveness to patient feedback. The inspection resulted in 18 recommendations, each of which the service had completed by October 2018.

In September 2018 the cardiac physiology service sought a conformity assessment from the United Kingdom Accreditation Service against Improving Quality in Physiological Services (IQIPS) standards. The service review highlighted good standards of staffing, safety practice, maintenance and clinical standards and made recommendations for improvement, such as consistent recording of safety checks on emergency equipment.

The haematology service was seeking accreditation by the Joint Accreditation Committee ISCT-Europe (JACIE) and had undergone an inspection in pursuit of this. At the time of our inspection
the outcome was pending and the work completed in lieu of accreditation demonstrated the motivation of the team to achieve consistently high standards of service.

Staff said NICE guidelines could sometimes restrict the scope of care they were able to provide and services were not always flexible. For example, staff in the pain team said they often had to reject referrals because they worked within narrow NICE guidance, which prevented them from reviewing patients outside of a specific criteria.

Staff accessed trust policies and procedures electronically on the intranet and through the prescribing information and communications system (PICS). This included clinical guidelines and medicine formularies. We looked at a sample of four clinical guidelines for antibiotic prescribing, acute kidney injury, acute chronic obstructive pulmonary disease (COPD) and venous thromboembolism (VTE) prophylaxis and found each to be up to date with evidence of regular review.

A dedicated stroke research nurse led multiple projects in the specialty to benchmark care and patient outcomes with the latest understanding and research. At the time of our inspection the stroke service was participating in four research and audit programmes that included hyper acute, acute and rehabilitation services. Specialist acute stroke nurse practitioners played a key role in research and audit projects.

The tissue viability team carried out a series of eight rolling audits to benchmark their care and patient outcomes against national and trust standards. Tissue viability nurses (TVNs) were aligned with each division and scheduled tissue viability quality audit (TVQA) audits every two weeks in medical inpatient areas in division C. TVNs used TVQA audits to assess tissue viability standards against NICE guidance and the team discussed results immediately with the ward manager and matron to facilitate practice improvement. The team carried out an observational repositioning audit in three medical inpatient wards in January 2018 and February 2018. The audit found 16% of patients were repositioned within four hours and 40% of patients were repositioned after a period of four hours. Healthcare assistants (HCAs) documented repositioning in 98% of cases although the audit found this often took place after they had repositioned several patients. The team established focus groups with HCAs and staff nurses to identify opportunities to improve the results and implemented changes to the documentation in the electronic records system to help facilitate this.

Divisional clinical education teams supported specialist teams in the completion and analysis of audits, which resulted in a multidisciplinary approach and supported staff to have the capacity to complete audits alongside their patient-focused responsibilities.

Cardiac catheter laboratories participated in the National Congenital Heart Disease Audit for data quality, which included case note audits and outcome audits to evidence standards of practice.

Clinical teams were research-active and promoted research with trainee doctors and other professionals in partnership with the adjacent university. Research was designed to achieve a range of outcomes including the exploration of patient experience, improvement of clinical outcomes and benchmarking of standards against national guidance. For example, teams had carried out research into safer blood administration and the recording of observations and an integrated nurse handover strategy between qualified and non-qualified staff. This had led to changes and improvements in daily handovers in medical wards across the hospital. A research team had carried out work to develop systems for the treatment of sepsis using proton pump
inhibitors, which reflected an international focus on developing treatment strategies.

**Nutrition and hydration**

Nurses carried out a nutritional assessment of each patient on admission using the malnutrition universal scoring tool (MUST) and updated this through periodic observations depending on the medical need of the patient. We looked at a sample of 36 MUST records in seven of the wards we included in our inspection. In each case the MUST score was up to date and staff had documented evidence of escalating a patient’s care to a dietician or speech and language therapist (SaLT) when more specialist support was needed.

Staff used a red tray system to identify patients who needed support with eating and drinking. Adapted plates, bowls and cutlery were available and staff had easy access to these.

Staff provided food diaries to patients at risk of malnutrition and HCAs had a lead role in ensuring patients completed them. A team of dieticians worked across medical services and provided individual patient support on referral.

On ward 313 on one day of our inspection a consultant prescribed four times daily water intake for a patient after finding them clinically dehydrated. The patient had complained of a dry mouth and being thirsty and their water jug was not within reach. Although the prescription would ensure nurses supplied water to the patient throughout the day the issue had arisen in part because ward staff had not acted on the risk of dehydration. We reviewed the availability of water jugs on a sample of two wards following this incident. On ward 514, 15 out of 21 patients had water or fluids within reach. On ward 313, 19 out of 28 patients had water or fluids within reach. A theme from our conversation with patients was that they perceived staff to be so busy they did not want to bother them by asking for help. This presented a risk that patients would become dehydrated.

One patient on ward 411 said they had enjoyed all but one meal in the two weeks they had been admitted and staff changed their meal on that occasion.

The cardiac catheter laboratory team followed best practice guidance by not starving patients prior to a percutaneous coronary intervention (PCI) procedure. This reduced the risk of post-procedure complications such as renal failure or vaso-vagal episodes.

The tissue viability team led monitoring of the completion of waterlow scores against the trust standard of completion within six hours of admission. The team worked with ward-based colleagues to investigate the use of the waterlow scoring tool when a grade one pressure ulcer was identified.

The SaLT team delivered care based on the international dietary dysphagic standardisation (IDSI), which provided a standardised approach to altering food and fluid diets to prevent choking and aspiration. Each hospital in the trust had a different caterer, which the SaLT team said resulted in challenges in sourcing appropriate foods for patients who moved between sites.

The SaLT team was trialling a ward-based, nurse-led screening programme for dysphagia to identify more accurately when patients needed a specialist referral.

The SaLT and dietician teams had led a project to identify their impact on patients receiving radiotherapy. The study found 88 bed days had been saved through use of the collaborative model of care.

Each inpatient ward was equipped with a pantry to encourage patients to eat or snack well between meals. This included nutritious, calorific snacks for patients at risk of malnutrition and
healthy snacks for patients on controlled diets. Fresh fruit was always available as well as cakes and savoury snacks such as cheese and biscuits.

Medical care wards performed consistently better than the national average in the annual patient-led assessment of the care environment (PLACE), with an average score of 95% achieved each year from 2015 to 2018. This was between 5% and 7% higher than the national average in each year.

**Pain relief**

A dedicated chronic pain service provided consultant-led care to patients in all medical specialties. Consultants carried out three ward rounds each week to review patients with pain care plans and reviewed new referrals on demand. The nursing team provided care for patients in services such as elderly care and complex care and secured additional treatments such as acupuncture and transcutaneous electrical nerve stimulation (TENS) therapy for short-term pain relief.

A clinical psychologist, a clinical physiotherapist and a clinical nurse specialist led the pain management programme. The team undertook initial patient assessments and then established a care plan that was in addition to the patient’s primary medical care plan. The team worked to guidance from the Faculty of Pain Medicine and Royal College of Anaesthetists Core Standards for Pain Management Services in the UK 2015 for patients with persistent pain. The team also used guidance and best practice standards from the British Pain Society, the NHS England National Low Back and Radicular Pain pathway and the CSPMS UK pain management programme and pain rehabilitation standards. The team offered a rolling eight-week programme that reflected the physiological and psychological elements of pain management.

The pain management team had audited patient outcomes from 2016 to 2017 and included feedback from patients. This indicated patients experienced significant improvements in mood, self-efficacy and physical performance and a retention rate of 88%

The pain management team carried out 10 audits from October 2017 to October 2018 to benchmark practice and analyse pathways and patient outcomes. Results indicated high levels of patient satisfaction with the team and significant focus on psychological outcomes, such as a higher than expected return to therapy rate. The team discussed results at divisional and clinical specialty governance meetings to ensure learning was multidisciplinary and involved senior staff.

A nursing documentation audit in 2018 identified poor standards of the completion of pain recording. In only 42% of cases nurses had recorded the frequency of planned pain assessment and in only 38% of cases had they documented specific pain care needs. Both pain teams were working with ward-based nurses to improve documentation and during our inspection we observed consistent standards of documentation in all 38 patient records we reviewed.

**Patient outcomes**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

**Queen Elizabeth Hospital – elective admissions**

From May 2017 to April 2018, patients at Queen Elizabeth Hospital had a higher than expected risk of readmission for elective medical admissions compared to the England average.

Patients in gastroenterology, clinical haematology and cardiology had higher than expected risks of readmission for elective admissions.
**Elective Admissions - Queen Elizabeth Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Queen Elizabeth Hospital – non-elective admissions**

From May 2017 to April 2018, patients at Queen Elizabeth Hospital had a similar to expected risk of readmission for non-elective medical admissions compared to the England average.

- Patients in general medicine and nephrology had lower than expected risks of readmission for non-elective admissions.
- Patients in medical oncology had a higher than expected risk of readmission for non-elective admissions.

**Non-Elective Admissions - Queen Elizabeth Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Queen Elizabeth Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in latest audit, August to November 2017. This was in line with the previous audits where the trust has gone between a C and a D grade.
Overall Scores

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The trust scored an overall grade for patient centred performance of C. This was in line with previous audits. Only scanning, specialist assessments and discharge processes scored a B or above in the most recent audit, with four domains scoring a D.

Patient centred performance

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<td>C↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

Similarly the trust scored a C grade for team centred performance and only the scanning, specialist assessments and discharge processes domains scored a B or above in the most recent audit.
We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 74.1%, which did not meet the audit minimum standard of 90%. The 2016 figure was 79.3%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.1%. This is within the expected range. The 2016 figure was significantly better than the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 70.6%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 70.4%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2017 was 36.9%. This is within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

A dedicated outlier nurse worked across the hospital to coordinate care for patients being cared for in wards outside of their medical specialty. Medical outliers numbered around 40 patients per day and this number increased to up to 100 patients during the winter. The outlier nurse provided an extra level of coordination for ward-based teams who were caring for patients that may have had needs outside of their expertise. The nurse worked to ensure consultants reviewed patients regularly regardless of their location and focused on reducing length of stay through effective communication between teams. Ward managers said this system worked well for outliers on their wards although in some cases they said it was difficult to obtain specialist medical review, particularly from gastroenterology consultants.

Allied health professionals (AHPs) monitored PICS for outlier patients to ensure they planned care and interventions. This meant patients treated as outliers outside of their medical specialty had equal access to therapy treatment.

An HIV consultant had led a project in the clinical decisions (CDU) unit to implement more proactive HIV testing for inpatients. The consultant and a clinical nurse specialist (CNS) provided an on-call service where a patient tested positive for HIV during their inpatient stay. This meant the specialist team could establish a treatment plan alongside the patient’s primary medical condition.

Although staff demonstrably reduced the impact of short-staffing on patient care and outcomes, patients were still sometimes affected by this. For example, on ward 313 a patient had a planned x-ray cancelled because there were not enough portering staff to collect them. Also on this ward
A patient said that minor requests were not fulfilled because staff were so busy. They had waited over 24 hours to be given medicine for an upset stomach despite asking multiple times.

AHPs used the PICS system to monitor referrals and in the previous 12 months there had been no missed referrals.

AHPs reviewed all falls patients and all patients who suffered a fractured neck of femur on a 24-hour, seven-day basis. The team worked with the specialist falls nurse to review falls on each ward and identify contributing factors including the time taken to refer patients.

The falls team devised a ‘back to the floor’ audit tool to align with the National Audit of Inpatient Falls and NICE guidance. The team carried out audits at a frequency based on level of risk in each division, based on incident reporting trends. The team carried out 41 ward or departmental visits from April 2018 to October 2018 and provided immediate feedback from each audit to the nurse in charge, who presented the results to preventing harm groups. The most recent audit results related to August 2018, which showed overall hospital compliance over the target of 95% was achieved in eight out of 15 aspects of falls prevention methodology. Areas for improvement included a need to use recognised tools to assess patients for risk who presented with confusion or delirium and to increase the use of the lying and standing blood pressure tool. The audit showed very low levels of compliance with the BP measuring requirement with the ambulatory care unit, the cardiac care unit, wards 516 and 622 and Edgbaston ward scoring 0%.

A clinician had introduced a commissioning for quality and innovation (CQUIN) project for alcohol and tobacco use. Planning had begun in April 2018 and the project had been implemented in September 2018, with recording of each patient’s alcohol and tobacco use recorded on PICS to enable staff to identify opportunities for brief intervention. The project was evidence-based and reflected research findings that patients are amenable to health promotion and outcome interventions if they are brief whilst they are an inpatient. The CQUIN included the option to refer patients to specialist organisations if a more formal programme of support would be beneficial and if the patient agreed. Results from the first month of data monitoring indicated staff asked 55% of patients about their smoking and/or drinking habits and noted these results. Where smoking levels were at potentially harmful levels, staff documented a brief intervention in 38% of cases. Similarly, staff documented a brief intervention for alcohol in 41% of cases where they considered the patient to be at risk.

**Competent staff**

From April 2017 to March 2018, 89.1% of staff within medicine at the trust received an appraisal. This is below the trust target for Queen Elizabeth Hospital of 90% but above the target for other sites of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental staff</td>
<td>294</td>
<td>300</td>
<td>98.0%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>116</td>
<td>120</td>
<td>96.7%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>285</td>
<td>305</td>
<td>93.4%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>554</td>
<td>607</td>
<td>91.3%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>599</td>
<td>662</td>
<td>90.5%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>274</td>
<td>303</td>
<td>90.4%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>651</td>
<td>733</td>
<td>88.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>1,796</td>
<td>2,100</td>
<td>85.5%</td>
</tr>
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</table>
From April 2017 to March 2018, 93.8% of staff within medicine at Queen Elizabeth Hospital received an appraisal compared to a target of 90%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>73</td>
<td>74</td>
<td>98.6%</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>169</td>
<td>173</td>
<td>97.7%</td>
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<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>116</td>
<td>120</td>
<td>96.7%</td>
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<td>Qualified healthcare scientists</td>
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<td>96.5%</td>
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<tr>
<td>NHS infrastructure support</td>
<td>76</td>
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<tr>
<td>Qualified allied health professionals</td>
<td>276</td>
<td>291</td>
<td>94.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>595</td>
<td>643</td>
<td>92.5%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>426</td>
<td>468</td>
<td>91.0%</td>
</tr>
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(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Clinical Educators (CEs) led a corporate education team with dedicated nurses based in medical specialties within each division. CEs supported new HCAs and nurses when they joined a ward or specialty, such as in induction and preceptorship and using divisional education programmes. The PDN team leader met with ward managers and divisional leads to identify areas of training needs, such as where a ward had experienced a trend in incidents or complaints. A separate, dedicated education team led training and development for agency and bank nurses.

Senior divisional teams had a demonstrable focus on staff development and training and the divisional leadership teams created a culture of action learning in their services and with staff in other areas interested in benefiting from this. Action learning is a specific approach to development based on the experiences, reflection and research of the staff members involved.

Some wards, such as ward 303, had a training coordinator dedicated to the development of their teams. Clinical specialties, such as chemotherapy, acute oncology and haematology had a dedicated education team comprising of a clinical educator, CNSs and administrative support.

Senior staff encouraged HCAs to apply for trainee nurse associate positions, which would give them access to more advanced training and development and increase their responsibilities. The senior leadership team for renal services had implemented band six development posts to help staff gain experience and had invested in opportunities for third year management students. The team planned to ensure the service remained sustainable in the future and to secure specialist treatment from competent staff.

The TVN team had a key role in education and learning and supported colleagues across multidisciplinary teams to develop their skills, through practical training, support with individual patients and a journal club. This team maintained links with community colleagues, including in adult social care providers and local authority teams, and delivered training and conference workshops as part of their education programme. The team was part of a national network and this relationship enabled them to develop remote video-led training and simulation training.

Nurses in each ward 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.
Staff on each ward were empowered to identify training that would help them to more closely meet patient’s needs. For example, staff on Edgbaston ward were arranging cannulation training so that they could initiate intravenous medicine administration and reduce delays that occurred overnight waiting for on-call medical staff. On ward 303 the ward manager facilitated access to a rolling programme of education and development, which staff said had improved retention as well as increased the specialisation of each individual.

The oncology team had developed a specialist induction module that enabled nurses without prior chemotherapy experience to safely work on the ward. This helped to reduce the impact of staff shortages on the ward and offered specialist development opportunities to staff.

SaLT and dietetics teams provided care across medical specialties as well as the clinical decisions unit (CDU). New therapists did not join the trust with skills in managing dysphagia, which added pressure to experienced staff as it meant they were taken away from their planned duties to provide ad-hoc training. Staff we spoke with said this left the service stretched and often unable to review each patient referred to them.

Divisional teams offered colleagues in other specialties access to training to broaden their skills and offer patients improved access to care. For example, CEs offered training in chemotherapy training and care to a wide range of nursing staff to help them understand treatment and symptoms when caring for patients with multiple conditions. Staff in the discharge suite had undertaken IV care training as part of a programme to broaden the range of patients they could safely care for.

The ward manager on ward 313 planned to introduce a diabetes specialist nurse role to provide more dedicated care for patients. At the time of our inspection diabetes nurses were based in outpatients and had capacity for limited support of inpatients. This would reduce the time patients waited to see a diabetes nurse and offer opportunities for staff for additional training as a retention and development strategy.

Consultants proactively used ward rounds as teaching and learning opportunities for junior medical staff and presented several learning points for each patient. This was particularly noticeable between consultants and foundation year 1 (FY1) doctors on ward 514, a stroke ward. In addition, stroke consultants had implemented a new on-call system for FY doctors on the ward. This meant if the consultant was called to the emergency department for a stroke emergency, the FY doctor accompanied them as a substantive learning opportunity. This was representative of the opportunistic learning culture fostered by all members of the medical team. For example, we observed junior doctors on ward 514 proactively using a patient’s scan results to improve the knowledge of nurses and HCAs.

FY doctors had access to structured teaching and learning sessions during weekly protected time for education. This included a joint geriatric medicine and stroke medicine session and a dedicated stroke session. In both cases junior doctors presented cases to facilitate discussion and learning and consultants facilitated the sessions. Hospital-wide, multi-specialty teaching was offered on a weekly basis and FY doctors told us they were supported and encouraged to attend these.

Most junior doctors we spoke with said training opportunities were tailored to them and they had regular contact with Royal College of Physicians tutors to establish annual learning objectives. Doctors told us they were offered development opportunities that helped them develop at their own pace and consultants facilitated learning in areas of interest to them. For example, one junior doctor was supported to set up and run neurology clinics as part of a substantive and challenging development plan. This was evidence of the clear focus consultants had on ensuring doctors developed into more senior grades through undertaking progressively more complex work. There was an exception to this on ward 411, where junior doctors told us teaching was infrequent and informal.
Nurses who led the ambulatory care unit service had undergone extended specialised training to admit and discharge patients without medical oversight, which enabled them to manage an extensive workload and broad case mix. This unit saw elective patients and significantly reduced pressure on specialist inpatient areas.

Nurses on Edgbaston ward took on progressively more responsible roles as they completed training and development opportunities. For example, the tissue viability link nurse had taken ownership of audits and NHS Safety Thermometer data in addition to completing leadership modules. Staff said that development was structured with good support and although it was challenging they felt the pace helped them keep momentum.

The practice placement team (PPT) supported trainee nursing associates (TNAs) and provided everyone with a named mentor. TNAs met with the workforce lead nurse to review their progress every two weeks as part of a structured support programme based on new guidance from the Nursing and Midwifery Council. The PPT offered support for trainees who had no previous experience of higher education.

Ward managers provided bank and agency staff who regularly worked shifts on their ward with access to training and development programmes to ensure they retained key competencies. For example, a bank nurse on ward 516 had undertaken non-invasive ventilation training to help them provide a full range of care without adding pressure to the permanent nursing team.

The trust had recognised the team on ward 517 with an award for their work in hypoglycaemia education and for their multidisciplinary work in raising diabetes self-awareness amongst patients.

The PDN dedicated to oncology services was leading a 12-month comprehensive sepsis audit, which they would present at a European Society for Blood and Marrow Transplantation conference.

Each division had a rolling programme of specialist study days for nurses who had been qualified for more than 12 months. For example, the division B programme included 10 specialist training days such as renal medicine and cardiac care.

**Multidisciplinary working**

AHP therapies teams provided a comprehensive and specialised service to medical patients, including a consultant-led sports and exercise service. Clinical specialists were based in general medicine, neurosciences, trauma and rehabilitation and physiotherapists and occupational therapists worked on a rotational basis, which meant they could be deployed to the clinical area of greatest need based on demand.

Clinical nurse specialists (CNSs) in multiple specialties provided dedicated care across medical care services. For example, transplant specialist nurses and lymphoma specialist nurses provided care on ward 625 one day per week each and haematology CNSs were based on the ward two days per week. CNS teams provided advanced levels of specialist care that complemented the nursing teams on each ward and offered ward teams opportunities for ad-hoc teaching and learning.

The complex discharge team (CDT) was co-located with the local authority safeguarding team and social workers, which facilitated consistent joint working in coordinated care. AHPs worked with clinical teams and the CDT to ensure discharge planning always reflected a whole-team approach.
Multidisciplinary working extended outside of hospital teams and staff worked with colleagues in the community and other organisations to coordinate care. For example, the senior discharge suite nurse worked with transport coordinators and managers in adult social care accommodation to secure transfers home for patients who would normally not be accepted when they remained in hospital after a time set by the home. This meant frail or elderly patients did not need to spend another night in hospital unnecessarily and demonstrated how effective cross-team working resulted in improved patient outcomes and experience.

Staff in all areas described good standards of communication and engagement across divisions. For example, the matron responsible for the discharge suite had developed improved working relationships and lines of communication with colleagues responsible for inpatient wards. This resulted in improved transfer processes from wards and meant staff could transfer patients with a wider range of conditions to the discharge suite. Staff said this was a significant improvement on previous arrangements as referral criteria had been excessively restrictive.

The senior leadership team for haematology and oncology had introduced new multidisciplinary working to improve patient experience and outcomes and to improve opportunities for staff. For example, the senior team worked with student nurses to encourage them to return to the service after they qualified and introduced a rotational staff nurse role to oversee the operation of patient pathways. Ward managers across medical inpatient wards engaged with student nurses to provide them with opportunities to return when they had completed their studies. The ward manager on ward 313 had successfully recruited two registered nurses through this initiative.

Multidisciplinary working was embedded in the cardiac catheter lab, including a cohort of staff who were scrub trained and daily multidisciplinary team meetings to review treatment lists for the day. All clinical staff were trained in the Ionising Radiation (Medical Exposure) Regulations (IRMER) and aware of how to contact the radiation protection officer.

Nurses and AHPs worked closely together to begin early tracheostomy weaning.

A multidisciplinary older person’s assessment and liaison (OPAL) team was based in the CDU and worked to support patients with complex social care needs to maintain health and wellbeing in the community when they presented at hospital in an emergency or a crisis. The OPAL coordinator worked closely with the team on Harborne ward to secure inpatients for patients acutely unwell with complex mental health or social care needs who could not safely be discharged to the community.

Each clinical specialty could provide services from multiple wards. In such cases ward managers developed close working relationships with their counterparts on other wards to share staffing and learning for service development. For example, the ward manager on ward 411, a neurological ward, had developed relationships with ward managers on the neurosurgical wards. This meant the team could pool staffing resources when one team was under particular pressure and enabled nurses to develop their skills in other areas. Medical teams worked similarly and the neurosurgery team visited ward 411 daily to work alongside the resident neurology team. The haematology team on ward 625 rotated to the outpatient haematology and chemotherapy clinics as part of a strategy to enable nurses to fully understand the patient pathway.

The manual handling team supported staff across medical inpatient areas when they needed help with patients with specific or complex needs. For example, staff on ward 518 said the team had been helpful in supporting them to care for a bariatric patient who needed additional equipment to be cared for and moved safely.

The hospital held a weekly grand round. This is a teaching and education technique used by doctors and medical students to review specific cases and apply learning to their own speciality.
Doctors we spoke with were enthusiastic about the opportunity and consultants said they encouraged all of their junior colleagues to attend where possible. The grand round was open to all interested clinicians and included both NHS and Ministry of Defence doctors as well as locum doctors and students.

AHP teams had variable vacancy rates. At the time of our inspection vacancy rates were:

- Podiatry 0%
- Dietetics 41%
- Physiotherapy 8%
- Occupational therapy 3.5%
- Moving and handling 11%

The senior team had appointed new staff to fill vacancies in the physiotherapy, occupational therapy and moving and handling teams and were awaiting final checks from human resources. The team had also shortened the administrative sign-off process for newly-qualified therapists by five weeks to improve the efficiency of recruitment and four senior healthcare assistants had started a physiotherapy training programme to help support the team.

Staff demonstrated resourcefulness and resilience when managing highly complex situations that involved multiple agencies and organisations. For example, the team on ward 517 had liaised with a range of community services and commissioners after a number of social care providers refused to accept a patient who was aggressive and violent. Senior divisional staff supported the ward manager to put in place additional levels of care on the ward and the multidisciplinary team worked with nurses to reduce the patient’s aggressive and help them to settle.

**Seven-day services**

The inpatient endoscopy unit had employed more nurse endoscopists, which enabled the team to offer a seven-day service in response to increasing demand.

The cardiac catheter lab opened five days per week and provided an on-call 24-hour, seven-day service for cardiac patients being cared for as inpatients.

The thrombolysis service was available 24-hours, seven days a week. A stroke nurse provided a first responder service from 8am to 12am and the on-call medical registrar provided the service from 12am to 8am. The thrombectomy service was available from Monday to Friday and the team planned to develop this into a seven-day service.

The ambulatory care unit operated 24 overnight beds on a 24-hour basis six nights per week, from Sunday to Saturday. The overnight beds closed at 8pm on Saturday and reopened at 12pm Sunday to provide capacity support to inpatient medical areas.

AHP physiotherapists provided 24-hour, seven-day cover. Overnight two physiotherapists were available for respiratory patients and two were available for general medicine. SaLT provided a seven-day referral system although therapists were not available on-site at weekends. All therapies services were available on bank holidays.

The multidisciplinary stroke service had been extended to include Saturdays although the AHP team resourced this from existing staffing, which significantly increased pressure on the service and stress on staff.

Medical staff were based on Edgbaston ward, a private ward, from 9am to 5pm with on-call cover from 5pm to 8pm. Outside of these hours the on-call medical team provided cover.
The physiotherapy team provided an acute respiratory and NIV service 24 hours, seven-days a week.

Health promotion

Health promotion was a key focus for staff in all specialties as a prevention strategy for specific conditions to improve quality of life. Ward teams encouraged patients to get out of bed and follow a daily routine to promote a speedy recovery as part of the national PJ Paralysis campaign. Occupational therapist support workers were based on wards and supported patients with this, encouraging them to move about safely, particularly at mealtimes. Staff ensured they delivered this particularly for elderly patients who usually lived in a nursing or care home and would need to be reassessed by the home if they were an inpatient for longer than 48 hours.

A specialist dietician worked with HIV positive patients to implement lifestyle changes that would reduce the risk of cardiovascular disease and improve bone density.

Multiple non-profit and community agencies had a presence in the hospital and promoted support groups, social activities and informative activities for patients, their relatives and carers. For example, one group organised a ‘come walk with us’ event that promoted gently exercise amongst older people while facilitating a historic tour of parts of the city.

The hospital was one of six solid organ transplantation centres in the UK and clinical staff encouraged people to engage with the NHS Organ Donation Register through the trust’s charity. For example, staff, patients and visitors had taken part in the 2018 British Transplant Games to raise awareness of the national register and provide a discussion point for staff with their patients.

Although printed health promotion material was readily available in each medical specialty, this was not regularly reviewed. For example, information leaflets in the relative’s room in ward 313 were untidy and disorganised and some were several years past their review date. For example, one leaflet advising patients and visitors on infection control risks had been due for review in August 2014 and a norovirus leaflet had been due for review in February 2017.

Ward teams were participating in the national ‘get up and go’ campaign to promote patients getting out bed, washed and dressed each morning. This was an evidence-based strategy that reduced the incidence of chest infections and provided pressure relief for patients with reduced skin integrity. We saw staff on ward 518 were passionate about this campaign and the whole team, including physiotherapists and non-clinical staff, helped patients at mealtimes to encourage them to eat socially in the lounge in chairs. The campaign included self mouth care for patients and nurses encouraged each patient to take control of their own oral hygiene.

A multidisciplinary team of AHPs, doctors, surgeons and pharmacists contributed to a liver transplant event day as part of a survivorship programme.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The trust combines safeguarding level 2, mental capacity and Deprivation of Liberty Safeguards (DoLS) training.

Queen Elizabeth Hospital

A breakdown of compliance for mental capacity and DOLs training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Queen Elizabeth Hospital is shown below:

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<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
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<tr>
<td></td>
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</tr>
<tr>
<td>Name of course</td>
<td>Number of staff trained</td>
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<tr>
<td>Safeguarding level 2/ DOLs and mental capacity</td>
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</table>

The trust’s 90% completion target was met this training module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in medicine at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 2/ DOLs and Mental Capacity</td>
<td>106</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff in the inpatient endoscopy unit demonstrated a good understanding of the principles of mental capacity and the Deprivation of Liberty Safeguards (DoLS).

The safeguarding lead nurse carried out mental capacity assessments and coordinated best interest assessments prior to a Deprivation of Liberty Safeguards (DoLS) application. They worked closely with ward teams to ensure they correctly used the Mental Capacity Act (MCA) (2005) and understood their responsibilities of care when patients experienced mental health challenges.

Clinical staff demonstrated working knowledge of the MCA, DoLS and best interest processes relevant to patients in their specialty.

Following a successful pilot in the clinical decision unit in July 2018, the clinical educator for mental health and the lead nurse for standards implemented a mental health care pathway booklet to support staff in coordinating care between mental health and physical health teams. The booklet helped staff to document and maintain an on-going mental health assessment of the patient, including their Mental Health Act status, identification of risks such as self-harm or suicidal intent and interaction with the rapid assessment interface and discharge (RAID) team.

The safeguarding team visited each patient with a DoLS authorisation in place as a part of a system to ensure staff used this process appropriately and that it was in the best interests of the patient. This helped to support staff in a complex process and meant patients were protected from inappropriate restrictions.

Following previous incidents, the team on ward 411 introduced a weekly checklist for patients with a DoLS authorisation in place. This provided assurance to staff that regular checks of patient safety and needs were maintained, including where they had additional responsibilities under the MCA. Divisional staff were working with IT colleagues to add a visual tag to the PICS system that would enable them to discreetly indicate which patients were being cared for under a DoLS authorisation or other MCA considerations.

Staff liaised with the safeguarding team to ensure they followed appropriate consent processes when carrying out invasive procedures on patients who lacked mental capacity. We saw examples of this on ward 411 where staff had fully completed capacity and consent checklists before carrying out lumbar punctures on patients with reduced understanding of the situation.
The trust had an established restraint policy and staff demonstrated awareness of this. However, application of processes for restraint amongst patients with a DoLS authorisation was not always consistent. For example, senior staff told us mittens would only be used on patients if a DoLS application had been completed. On ward 411 staff had fitted mittens to two patients who were unable to consent. In one instance was no DoLS in place. We spoke to a staff nurse about this and reviewed the nursing and medical notes for the patient. There was no documented assessment of the need for mittens. The ward manager told us they did not need to complete a mental capacity assessment because the patient was being cared for under a Mental Health Act Section 3 order, which was incorrect. In addition, nurses on the ward demonstrated confusion about the provision of medical treatment for the physical health of a patient cared for under Section 3. Staff had completed a risk assessment for the use of mittens in a second patient and nurses had carried out a review of the DoLS assessment after two days but there was no documented evidence of a medical review.

We reviewed the medical records of five patients with a DoLS authorisation in place on ward 411. Medical staff had documented a mental capacity assessment for each patient although one was not appropriately completed. For example, a doctor had noted in their assessment only that the patient was confused, which was not of sufficient detail. We spoke with the ward manager about this who agreed it was vague and said they would address it.

Is the service caring?

Compassionate care

We have included data from the pre-acquisition period for Queen Elizabeth Hospital in this analysis. Because it related to the same legal entity, University Hospitals Birmingham NHS Foundation Trust, we have used this to form part of our judgement. Data for Heart of England NHS Foundation Trust has only been included post-acquisition.

Queen Elizabeth Hospital

The Friends and Family Test response rate for medicine at the Queen Elizabeth Hospital was 21% which was worse than the England average of 25% from July 2017 to June 2018.

A breakdown by ward is below (please note, only wards with at least 100 responses are shown).

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bournville Ward</td>
<td>133</td>
<td>41%</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>296</td>
<td>61%</td>
<td>100%</td>
</tr>
<tr>
<td>Edgbaston Ward</td>
<td>129</td>
<td>14%</td>
<td>100%</td>
</tr>
<tr>
<td>Harborne Ward</td>
<td>199</td>
<td>28%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 302</td>
<td>167</td>
<td>14%</td>
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<td>8%</td>
<td>80%</td>
</tr>
<tr>
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<td>18%</td>
<td>83%</td>
</tr>
<tr>
<td>Ward 726</td>
<td>521</td>
<td>35%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Key

Highest score to lowest score

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.
Relatives of a patient on ward West 1 said they were very happy with the, “…care, compassion and cleanliness” on the ward. Two patients on this ward said they found the attitude of all staff to be kind and caring and one patient said, “They’ve [staff] made my two weeks here much easier thanks to how lovely and kind they are.” On ward West 2 one patient said, “Staff are so caring. It’s a lovely place here, if I have to be in hospital I’m glad it’s this one.”

We spoke with three patients on ward 625 who all said they felt staff were kind and friendly. They said it was often challenging to get their attention and they had to wait for their call bells to be answered because staff were so busy and that the ward could be noisy at night. We spoke with the nurse in charge about this who said all three patients were near the main entrance to the door and so they were disturbed by this during the night.

All of the patients we observed were well dressed where appropriate, clean and tidy, which demonstrated staff maintained their dignity.

On ward West 2 the relative of a patient who had previously received care on the ward returned regularly to reminisce with staff. Staff were kind, welcoming and compassionate and took time to talk to the person and comfort them, such as by holding their hand when they became upset.

Patients in elderly care wards had access to dogs trained to provide safe companionship. This service was available on demand and the trust had ensured it met appropriate risk assessments. Animal therapy was evidence-based and staff encouraged it to reduce anxiety and social isolation and promote patient wellbeing.

Patients on ward 517 spoke highly of the ward team. A relative of one patient said, “I do not know how people work so hard so constantly. They have such patience and nothing is too much trouble.”

On ward 313 we observed a physiotherapist told a patient who needed to open their bowels to do so in their pad rather than escort them to the toilet. This was undignified because the patient had been fully independent before admission to the hospital and made it clear they wanted to use the toilet rather than to open their bowels in their bed bay.

Staff on ward 514 demonstrated how they went above and beyond their responsibilities to show extended kindness and compassion to patients. For example, a group of 12 nurses and HCAs had helped to clear the garden of a patient who sustained life-changing injuries and lost their ability to manage their garden. The patient had been an active gardener and this gesture demonstrated the commitment of staff to deliver care beyond immediate clinical need.

Harborne ward had an energetic, bustling atmosphere and staff were clearly involved closely with patients and their wellbeing. Staff were demonstrably warm, friendly and attentive and knowledgeable about the needs of patients at risk and how to overcome any challenges with dignity and respect.

Relatives of patients on ward 411 said they were “very happy” with the standard of care they had seen and commented on the kindness and compassion of staff.

A lead nurse for dignity and care was in post and worked with ward teams to identify modifications to the environment that could improve patient services.

In addition to the examples of compassionate, kind care we observed during our inspection and in speaking with patients and relatives, staff documented their focus on patient interaction in morbidity and mortality records. Where patients had been cared for on a palliative pathway in
medical specialties, doctors consistently noted when they had worked with relatives to provide a comfortable, peaceful death. Where the wishes of relatives had raised concerns with doctors about a patient’s comfort, they documented how they approached this tactfully and empathetically. For example, this occurred when doctors believed that invasive attempts to resuscitate a person would cause them pain or distress but relatives wanted doctors to attempt it.

Medical care performed variably in the privacy, dignity and wellbeing measure of the annual patient-led assessment of the care environment (PLACE). Annual scores declined year-on-year between 2014 and 2018, with the exception of a small rise in 2017, from 98% to just over 90%. However, performance in each year was significantly better than the national average and 7% better in 2018.

**Emotional support**

Staff proactively offered patients and their relatives assistance in accessing counselling services. A faith and community centre and on-call chaplain was available 24-hours, seven days a week. The centre provided multi-faith space for prayer, meditation and conversations and printed information for a range of needs such as bilingual Sikh prayer books. The centre team provided organised prayers and congregational sessions, including holy communion, Catholic mass and Muslim congregational prayers.

The chronic pain service team was proactive in referring patients to a psychology service as part of their care plan.

Staff on Harborne and Bourneville wards demonstrated extended skills in providing emotional support for patients living with highly complex social and mental health needs. Both teams provided multiple examples of how they supported patients who were feeling anxious, distressed or emotional. For example, when a patient was transferred to Harborne ward from another inpatient area wearing mittens to prevent them removing their catheter, the team worked with them to understand why they had tried to do this and remove the contributing factors. This resulted in the team removing the mittens, which provided more dignified and less restrictive care.

Relatives of patients on Edgbaston ward said staff had understood the distress of their relatives and provided individual care to help them relax, such as in one instance when a nurse brought in board games.

Therapies staff used rehabilitation and activities of daily living (ADL) time opportunistically to establish patients’ emotional state and needs and to provide reassurance and support ahead of their discharge. For example, patients often felt apprehensive about supporting themselves in daily tasks and the therapies team worked with them in the ADL suite to understand their fears and address these with practical guidance and emotional support.

Staff were trained to use the trust principles for carers policy and guidelines for carers staying overnight on the ward policy to ensure carers were supported and cared for themselves when visiting patients.

The dignity in care team provided resources, training and support to staff across medical care services. The team helped staff to communicate effectively and empathetically with patients experiencing difficulties and those who had complex needs, including carers and relatives.

**Understanding and involvement of patients and those close to them**

Non-clinical staff spoke positively about their work to understand and involve patients. Housekeeping staff and ward clerks told us they felt proud of the teamwork and family feel of each
ward and said this reflected a genuinely caring approach to patients and understanding their needs.

The relative of a patient on ward West 1 said they were pleased with how their family member was being cared for but said as they were always last to be served at mealtimes, the food was always cold.

One patient on ward West 2 said, “Staff come to you for the slightest whimper. They notice everything, it’s very reassuring.”

On ward 313 we observed a physiotherapist and an occupational therapist work together to help a patient get out of bed and sit up. They were patient, kind and used their knowledge of the patient to help them with a sense of humour that demonstrably improved the patient’s mood and willingness to engage. On this ward a patient said, “Individual medical teams have explained what’s happening in their small area of interest although no-one has explained what’s happening overall. Some more joined-up communication would be a big help.” Another patient on this ward said, “Everyone is excellent about their own field but nobody seems to be looking after the whole. There’s no single person to talk to about everything and it all seems a bit disjointed.” A relative of the patient said, “After 49 days of being here we’re just starting to get to know who is who. Staff are so busy they rush around and we’ve got no idea what they’re doing because they’re too busy to tell us.”

Renal services had established a project with a specialist non-profit organisation that helped patients who received dialysis to access benefits, welfare and financial support. This arrangement was evidence of the in-depth understanding staff had of patient’s needs, including needs that extended before the clinical environment. For example, staff acknowledged the worry and anxiety patients could experience whilst an inpatient when they were thinking about the challenges they would face at home.

Clinicians in the stroke wards documented clear summaries of the discussions they had with patients and their relatives about care and treatment plans. For example, in one set of notes we looked at a consultant had documented the discussion about the pros and cons of nasogastric feeding and evidenced how the patient’s relatives believed they would prefer to be cared for.

Relatives gave variable feedback on their involvement in care. On ward 514 three relatives said they did not feel staff had been proactive in keeping them informed about the care of their family member. They said they had waited for three days to meet the palliative care team and they had still not been to see them. One family member said, “To start with everything was fine and the consultant told us what to expect. But since then no-one has really spoken to us. [Patient] has a [terminal condition] and we want to take them home but none of the doctors or nurses seem to know what’s happening.”

Staff in the discharge suite said patient’s relatives were often unaware of discharge plans and not ready for their arrival home, which caused delays and confusion before patients could safely leave the hospital.

Staff on Bourneville and Harborne wards said they frequently encountered aggression and challenging behaviour from patients who had mental health needs, including complex safeguarding situations. The ward team had undertaken training in de-escalation techniques and demonstrated detailed understanding of how to involve patients and their relatives in care delivery to avoid causing distress or anxiety.

Nurses spent time with the relatives of patients who had a Deprivation of Liberty Safeguards (DoLS) authorisation to help them understand its meaning, purpose and implications. Staff on
Bourneville ward demonstrated how this helped to reduce misunderstandings and the worries frequently experienced by relatives.

Staff on Harborne ward provided care above and beyond patient’s clinical needs as part of their extended understanding of specific patient groups. For example, the team recognised elderly patients living with dementia often felt disorientated and isolated. To address this staff researched household items from the era patients may be more familiar with and sourced these from charitable organisations. The team had collected a stock of crockery for social events and held a tea party for a royal wedding. The team on ward 518 contributed bunting and cake themselves to organise a royal wedding party for a patient who said they had never seen one before.

The team on ward 625 had redeveloped daily handover and patient review processes to make them more patient-focused and to promote the involvement of patients in their care. For example, staff used a new checklist to document patient’s communication needs and discussions with patients about sensitive subjects.

Each inpatient ward contributed to a monthly venous thromboembolism (VTE) audit focused on the understanding and involvement of patients in their care. This helped ward managers and their teams to identify area of good practice and opportunities to improve how staff involved patients. The latest audit results, from September 2018, reflected variable performance in levels of patient understanding. For example, 36% of patients said they had been given a VTE leaflet on discharge and 48% of patients said they were unaware of the signs of VTE. However, 72% of patients said they were aware of factors that increased VTE risk and 64% said they were aware of VTE prevention methods, both of which reflected a significant improvement of at least 10% from the previous audit results. The practice development team addressed the shortfalls in practice through ad-hoc teaching and the publication of a ‘myth buster’ guide to remind staff of the importance of VTE discussions.

The transfer team demonstrated empathy and engagement with patients when they were being transferred. We joined a member of the transfer team in their duties and observed a further four transfers. In each case staff rapidly developed a rapport with the patient, put them at ease and matched their interaction to the patient’s mood. For example, one patient demonstrably enjoyed the member of staff’s sense of humour whilst another was appreciative of a more sombre conversation. We asked a member of the transfer team about this who told us that while their primary concern was to move patients safely, they could only achieve if this if the patient trusted them and understood what was happening.

Three patients on ward 518 said they felt involved in their care planning and understood as much of their treatment plans as they wanted to. One patient said, “A doctor visits me every morning and gives me an update.” Another patient said their planned discharge date had been changed a few times and they were happy that a doctor explained the reason for this each time.

Patients on ward 517 said they appreciated the level of contact from the consultant and said they felt well informed about their care.

AHPs worked with patients at risk of falls to ensure ward staff achieved a balance between reducing risk and promoting independence. For example, the team found patients who experienced a fall often did so whilst trying to maintain their independence. They had capacity to make their own decisions and the AHP team involved them in risk assessments and care planning.

Although inpatient wards had designated visiting hours to ensure patients had enough rest time, staff ensured this was balanced with each patient’s disposition and needs. For example, the team
on Edgbaston ward facilitated an overnight stay by a relative as they were involved in care giving at home and the patient was distressed.

NHS Services Seven Days a Week Forum's seven-day services priority standards included a requirement that patients be made aware of diagnosis, a management plan and a prognosis within 48 hours of admission. The trust had audited this measure in June 2018 and found average compliance at 97%, with 99% compliance on weekdays and 90% at weekends. The weekday compliance figure reflected an improved of 6% from the previous year and the weekend figure reflect a deterioration of 7%.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

From March 2017 to February 2018 the average length of stay for medical elective patients at Queen Elizabeth Hospital was 5.1 days, which was shorter than the England average of 6.0 days.

Average lengths of stay for elective specialties:

- Average lengths of stay for elective patients in medical oncology and clinical oncology were shorter than the England averages
- Average length of stay for elective patients in cardiology was similar to the England average

**Elective Average Length of Stay - Queen Elizabeth Hospital**

Over the same period, for medical non-elective patients, the average length of stay was 6.2 days, which was similar to the England average of 6.4 days.

Average lengths of stay for non-elective specialties:

- Average length of stay for non-elective patients in nephrology and medical oncology were longer than the England average
- Average length of stay for non-elective patients in general medicine was similar to the England average
Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Edgbaston ward provided care for private patients without being part of a single medical specialty, although most medical patients were admitted with needs in liver care or cardiology. This meant the clinical team provided care for patients with a wide range of medical conditions, including post-operative patients. The senior nursing team discussed the skill mix of their staff with clinicians referring patients to the ward, including the medical team in the emergency department and the clinical decision unit. This enabled them to plan a safe admission process and treatment plan for each patient and ensured they did not admit patients they were not able to safely care for. Systems were in place to ensure patient care was not affected by the differences between the private service and the NHS service.

The senior team on ward 517 had developed the service into an acute short-stay ward that assisted in providing care for patients who attended the hospital through the emergency department and the clinical decisions unit. The ward team could accept patients with a wide range of needs and arrange specialist staff and resources from across the hospital. For example, if a patient was admitted with a mental health need or with dementia, the matron ensured staff with training in these areas would be on shift for the patient's admission and on-going care. A dedicated team of junior doctors worked to carry out tests and diagnostics quickly to ensure patients did not remain an inpatient longer than necessary and 50% of patients were discharged within 24 hours of admission.

Wards West 1 and 2 were older people’s care wards with one for female patients and one for male patients. All inpatient wards adhered to single-sex accommodation principles.

Staff in the oncology service had extended the pre-chemotherapy clinic to increase capacity in response to a significant increase in demand. They introduced patient bleeps, which meant patients could leave the clinic while waiting for their chemotherapy, to alleviate overcrowding in the waiting room. Staff introduced this after noting the waiting room was often full to capacity and patients had to stand or sit on the floor.

The chemotherapy reception desk was staffed by a department separate from the oncology team and due to staff shortages, was only manned until 4pm. This meant patients arriving into the waiting area had no immediate point of contact and we observed this caused distress and frustration. Although managers covered this when they could, this meant they were taken away from their usual tasks.

A length of stay strategy group had worked to increase capacity in the ambulatory care unit using
11 specific workstreams to increase capacity in the medical inpatient wards. For example, a chemotherapy workstream had resulted in patients attending ambulatory care directly, which saved one inpatient bed on each occasion. The ambulatory care team had adapted the unit to provide care for frail patients for up to three days as part of a nurse-led initiative to increase capacity efficiency. Other pathways demonstrated a focus on improving services in line with the needs of the local population and trends within the hospital, such as in vascular treatment. Workstream leads worked in consultation with ward-based staff and identified opportunities to provide care safely in the ambulatory unit to reduce pressure on inpatient areas.

The division A team had developed and implemented a clinical nurse specialist (CNS)-led liver programme, which provided patients with more consistent treatment plans on discharge.

The vascular access team attended patients on wards to insert lines. The team did not have an established base or treatment area and the senior divisional team had identified a clinical area for them that was in the process of refurbishment.

The senior haematology and oncology team had introduced clinical pharmacy technicians who worked from 6am to take patient blood and ensure results were back from the laboratory in time for the morning ward round. This meant clinical teams reviewed patients using their latest blood results, which reduced delays in treatment decisions and diagnostics during the day. Technicians had extended training such as central line access, which provided nurses with critical support during handover periods.

Four cardiac catheter laboratories were on site including one primary percutaneous coronary intervention (PCI) lab. Labs were equipped for transcatheter aortic valve implantation (TAVI) procedures, which enabled patients to undergo valve replacement in a minimally invasive procedure. A consultant and matron governed the waiting list for heart failure patients.

The cardiac catheter lab team operated a ‘hot lab’ that was available at all times for patients anywhere in the hospital who experienced a myocardial infarction.

The ambulatory care unit operated as a nurse-led elective care area with a broad clinical case mix. The unit had 24 overnight beds and 57 trollies with approximately 70 patients admitted daily. Typical care included liver biopsy, lung biopsy, kidney ultrasound, cardio angiogram and iron infusions. Staff had developed specialist pathways to deliver care to patients from inpatient wards such as the transactional catheter embolization (TACE) pathway. This pathway had saved 45 inpatient bed days from April 2018 to October 2018.

The trust organised medical care in line with the Academy of Royal Colleges Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients. This meant care was delivered on the principle that each patient had a named consultant and transfers of care were minimised. Each ward and clinical area had well-defined working practices to adhere to the guidance and ward managers could track this using PICS. We saw evidence from the outcomes of complaints that where staff understanding of the role of the named consultant fell short of requirements, senior divisional staff took appropriate educational action.

Consultants in medical specialties said they felt overall processes were smooth and contributed to the responsive care of patients. For example, a general medicine consultant said radiology and microbiology test results were always returned quickly. A locum consultant said they were always happy with how efficiently processes operated in the hospital. They gave an example of obtaining two CT scans, a pacemaker check and an echocardiogram completed and written up within 48 hours for a patient who subsequently needed surgery. They said this was the only hospital they had worked in where such infrastructure existed.
The inpatient therapies team led ADL assessments using overnight accommodation in the therapies suite and an inpatient gym.

Therapists provided care in an inpatient gym that patients had access to as part of a structured rehabilitation plan or on an ad-hoc basis. The team provided highly specialised care, such as a rehabilitation and recondition programme for patients who had deconditioned after failed transplants. Exercise specialists and clinical leads offered scheduled classes for patients receiving treatment in limb medicine, neurology, elderly care and cardiac rehabilitation. ADL suites were available in the therapies departments and included well-equipped bathrooms and kitchens designed to replicate equipment patients had at home. For example, the kitchen included an electric cooker and a gas cooker so that patients could practice with the equipment most familiar to them.

Therapies teams had established a pilot scheme with a community trust to substantially reduce the waiting time for community-based therapy. Patients previously waited up to 44 weeks for a community therapist review. The new pilot arrangement meant a community therapist reviewed patients on their day of discharge and accelerated the package of care delivery.

Clinical health psychology support was provided in the chronic pain service, division C medical services, renal medicine, cardiac medicine, heart and lung transplant, intestinal failure and cancer and oncology services.

**Meeting people’s individual needs**

The outlier nurse provided on-demand support to patients living with dementia or mental health needs when they were cared for outside of the most appropriate medical specialty. For example, if all of the older people’s wards were full, a patient living with dementia might be cared for on a medical inpatient ward where the team were less experienced in meeting these needs. The outlier nurse helped ward teams deliver care and access resources and ensured they met patient’s needs. This nurse managed the transfer team, which gave them closer oversight of patient movements around the hospital and outlier admissions. At least one consultant and one specialist registrar in each medical speciality was responsible for medical outliers each day and supplemented the cover provided by the dedicated nurse.

Harborne ward provided dedicated care for patients who were medically fit for discharge and awaiting a package of care. Patients with complex social care needs were often cared for in this ward and the outlier nurse supported elderly patients in this ward whose discharge was delayed due to safeguarding needs.

AHPs said they found older people on ward West 1 and 2 benefited from the sense of community the ward layouts enabled.

Inpatient wards maintained activities resources such as games and playing cards for staff to use in delivering enhanced care.

Staff continually looked for new ways to further meet patients’ needs to improve their experience and ensure the service maintained momentum. For example, to improve the experience in the discharge suite the team started earlier opening hours, from 7.30am and provided breakfast that could be ordered in advance. They had also refurbished the lounge, arranged for TVs and artwork to be installed and rearranged seating to enable patients to talk to each other.

A dedicated learning disability nurse provided specialist support to patients, their relatives and staff on wards in coordinating care.
Staff used the national ‘all about me’ hospital passport and care plan to document the holistic needs, including their social care needs, of patients with complex conditions. This included a social and personal history of the patient, which staff used to develop a more in-depth understanding of each individual. This helped clinical teams to establish contributing factors to medical conditions and coordinate complex discharges with social care colleagues. Staff on Bourneville ward demonstrated how they used this tool to meet individual patient needs.

Staff provided printed and digital information in a range of formats, in line with the NHS Accessible Information Standard. Information was available in Braille, audio, large print and a range of other options, including on coloured paper to help patients with specific visual needs. The dignity team provided communication boxes that contained tools to help them communicate. The boxes included a hearing amplifier, a spectacle repair kit, a magnifying glass, a dyslexic ruler and a British Sign Language fingerspelling sheet.

Significant engineering and planning solutions had been implemented to make access to the discharge lounge as straightforward as possible. This included a through-road for ambulances to aid the timely pick-up of patients and free parking for relatives attending to pick up their family member.

An occupational therapist and a physiotherapist were dedicated to Harborne ward and worked to maintain each patient’s standard of mobility and movement whilst they were waiting for discharge. The team work with complex discharge colleagues to implement further rehabilitation if discharge was delayed to a level a patient lost the benefit of their previous inpatient therapy.

AHPs worked across all medical wards to offer patients strengthening exercises and cognitive tasks to help speed their recovery when their care plan did not include formal or substantive therapist-led rehabilitation.

Speech and language therapists and dieticians had established a new pathway for patients receiving radiotherapy. The pathway structured a care plan that focused on daily wellbeing and nutrition and aimed to reduce inpatient admissions.

The heads of therapies had implemented extended scope AHP practitioners to increase the complexity of care the team could provide and reduce the reliance on medical ward teams. This included non-medical prescribers in respiratory and neurosciences and practitioners with competencies in Botox and magnetic resonance imaging (MRI).

A team of clinical specialist AHPs and case workers had established a specialist hyper-acute stroke rehabilitation project that worked with external agencies to coordinate care for patients with life-changing trauma injuries.

The therapies service had a stock of over 250 wheelchairs and highly specialist chairs sourced from charitable funding. The department had a workshop with staff who modified equipment such as walking sticks to meet individual needs. Staff provided printed information for patients that explained the equipment they were taking home with them including pictures of how to use the equipment and what to do if something went wrong.

The dementia team had published a comprehensive, high-visibility campaign to improve awareness of the condition and to empower staff to feel more confident in communication and care delivery. The guide included examples of completing a high-quality hospital passport and national guidance from specialist dementia organisations.

Inpatient wards improved their performance in the disability and dementia measures of the annual patient-led assessment of the care environment (PLACE) between 2017 and 2018. In 2018 the
hospital scored 88% in the dementia score, an improvement of 3% from 2017 and 90% for the disability score, a slight improvement from 2017.

Access and flow

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

From August 2017 to July 2018 the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.

![Graph showing RTT rates for University Hospitals Birmingham NHS Foundation Trust and England average from August 2017 to July 2018.]

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to July 2018.

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<th>Result</th>
<th>England average</th>
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<tr>
<td>General medicine</td>
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</tr>
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</tr>
<tr>
<td>Cardiology</td>
<td>92.9%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>92.4%</td>
<td>91.0%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to July 2018.

From April 2017 to March 2018, there were 1,411 patient moving wards at night within medicine.

The wards with the highest number of ward moves at night were:
- Acute oncology unit with 201 moves (14.2%)
- Ward 302 (Renal) with 153 moves (10.8%)
Each ward was equipped with an electronic display that displayed patient location and clinical status in real time. This enabled staff to track planned treatment and to monitor transfers and discharge progress.

The site team led four-times daily hospital-wide bed meetings with representatives from each division and other services such as ambulance transport. This process meant staff coordinated bed space and capacity collaboratively to identify the most appropriate place of care for patients, including those awaiting admission from the ED.

Ward managers and flow coordinators used the ‘red to green’ system for discharge planning. This involved monitoring all of the factors that needed to be in place for each patient to have a safe and smooth discharge. Matrons and other staff responsible for capacity and flow met weekly to review patients with delayed discharges or extended stays and coordinate their care. All of the staff we asked about this said it reflected an improvement on their previous system and had reduced the average length of stay in each area. The local ambulance trust planned to trial placing a discharge coordinator in the hospital to support inpatient teams to improve discharge processes. This reflected the continual drive from multidisciplinary teams to identify new ways of working to improve performance and patient experience.

Two non-emergency transport coordinators were in post and worked with discharge teams and flow coordinators to ensure discharge transport processes went smoothly.

A newly-formed transfer team had been in place for two weeks at the time of our inspection as a pilot scheme. Dual-role HCAs and porters provided a dedicated, on-demand service to patients awaiting transfer to the discharge suite or another ward prior to discharge. This team reduced pressure on the porters and meant transfers were completed more quickly.

Staff on Edgbaston ward told us delayed discharges could sometimes occur because there were no medical staff permanently based on the ward to complete electronic discharge summaries. The senior team on this ward were working with divisional colleagues to scope the introduction of nurse-led discharge summaries as a solution to reduce delays.

Ward managers, matrons and flow coordinators used an electronic patient information system to identify and track patients awaiting discharge. The system highlighted the final steps needed in each case, such as a medical discharge summary or a physiotherapy care plan. This enabled staff across the hospital to identify patients ready for discharge and prioritise their final care to make beds available for new patients more quickly. The system enabled ward teams to manage access and flow in the most appropriate manner for their patients, which provided flow coordinators with support on each ward. A matron was dedicated to capacity and flow each day and worked with the outlier nurse to plan patient admissions, transfers and discharges. Matrons met daily prior to site capacity and bed meetings to assess each ward and the demand on the service from patients waiting in the emergency department.

Three patients we spoke with in the chemotherapy unit said they were happy with the timeline of their treatment, from the decision to treat to their first consultation and first dose of chemotherapy.

The senior divisional team was working to increase capacity in the endoscopy service through better use of ambulatory care.

The discharge suite team was trialling a new referral process to reduce delays in transferring people and increase capacity. This included issuing new, broader inclusion criteria and trialling the use of the electronic records system for referrals instead of phone calls. This significantly reduced the time ward nurses and discharge suite nurses needed to spend coordinating transfers...
on the phone, which reduced the potential of delayed transfers. Two non-emergency transport team members were based in the lounge and staff had access to the patient transport booking system, which had improved efficiency in transport booking. This was part of a feasibility study to identify if the presence of two dedicated staff produced overall improved results and would be implemented permanently if this was the case. The divisional team had prepared a briefing and information leaflet on the new work with the discharge suite and this was readily available on the intranet.

Staff in the discharge suite said delays in obtaining to take away (TTA) medicines were frequent and blister packs of medicines could routinely take up to four hours to be ready and an instance of one patient waiting 12 hours for their medicine.

A dedicated flow coordinator was based on ward 303 to oversee patient admissions, transfers and discharges in the renal service. This individual supplemented the site team and work carried out by matrons and ward managers and provided additional support for patients referred from the national on-call referral system (NORSe). The service was impacted by the lack of regional capacity for acute dialysis and lack of outpatient facilities to follow-up patients once they were discharged. Colleagues in renal outpatients had established virtual clinics and community bases to begin to address this.

A dedicated transfer team, based on ward 516, supported staff and patients in the clinical decision unit (CDU). Team members worked with the CDU coordinator to ensure the timely transfer of patients to inpatient wards. The team maintained oversight of bed availability, which removed the risk that patients would be transferred to a ward in which their planned bed was not yet available.

The occupational therapy team had reduced the average length of stay for patients who needed community-based care packages by 2.4 days through significantly improved partnership working with social workers and by carrying out more comprehensive pre-discharge assessments.

Through cross-division work to implement improved care pathways and increase use of the ambulatory care unit, 45 bed bays had been saved in the inpatient oncology service over a six-month period.

Heads of therapies worked with senior division C staff towards a goal of reducing the average length of stay for therapy intervention patients by six days.

Heads of therapies had secured funding for a dedicated porter team, which would save therapists’ time that they would use for more patient contact time.

Learning from complaints and concerns

From April 2017 to March 2018 there were 201 complaints about medical care across the trust as a whole. The trust took an average of 42 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Of the 25 complaints still open at the time of reporting all had been open longer than the trust target of 30 working days, the longest being open for 231 working days.

A breakdown by site is below:

- Queen Elizabeth Hospital: There were 104 complaints, the main themes were patient care with 30 complaints (28.8%), clinical treatment with 20 complaints (19.2%), communications with 18 complaints (17.3%) and admissions, discharges and transfers with 13 complaints (12.5%)
- Birmingham Heartlands Hospital: There were 48 complaints, the main themes were all aspects of clinical treatment with 28 complaints (58.3%) and admissions, discharge and transfer arrangements with 11 complaints (22.9%)

- Good Hope Hospital: There were 35 complaints, the main themes were all aspects of clinical treatment with 16 complaints (45.7%), communication/information to patients with five complaints (14.3%) and admissions, discharge and transfer arrangements with four complaints (11.4%)

- Solihull Hospital: There were 14 complaints, the main theme was all aspects of clinical treatment with eight complaints (57.1%)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From April 2017 to March 2018 there were 727 compliments within medicine.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>689</td>
<td>94.8%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>20</td>
<td>2.8%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>9</td>
<td>1.2%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>7</td>
<td>1.0%</td>
</tr>
<tr>
<td>Birmingham Chest Clinic</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Morris House</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total</td>
<td>727</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

From April 2018 to October 2018 the trust received five formal complaints about inpatient medical care. Three complaints related to communication issues, one related to patient care and one related to staff attitude. In each case staff had made a timely acknowledgement, offered an apology and carried out a thorough investigation.

The trust complaints policy was available in each ward or clinical area and in waiting areas in printed format. The trust also provided access to the policy on the public website, including links to the trust complaints department, the patient advice and liaison service (PALS) and contact details for regulators.

Staff we spoke with were aware of themes of complaints and compliments in their usual area of work. For example, staff on ward 517 said their most frequent compliments referred to how they made patients feel valued. Staff on Edgbaston ward said patients often complimented them on the friendly and caring atmosphere on the ward.

Divisional and site teams had introduced a ‘10 before 10’ discharge programme to address a trend of complaints relating to delayed discharges in 2016/17. The programme focused on discharging 10 patients prior to 10am seven days a week to facilitate flow for the rest of the day. This worked successfully and senior staff said complaints about delayed discharges were rare as a result.

Staff in each area demonstrated learning from previous complaints such as changes in practice. For example, following complaints in ward 303 about communication and coordinated care, the team introduced standard practice that the nurse in charge joined each ward round.

We reviewed the trust’s investigation and correspondence in relation to a sample of five complaints received between April 2018 and October 2018. In each case the trust provided a timely acknowledgement and carried out a detailed investigation that involved staff in each
department included in the complaint. The divisional head of nursing led each investigation and the executive chief nurse maintained oversight of the final response. Where a complaint included services provided by an external organisation, the trust provided the contact details for the complaints team of that organisation and explained why the complainant needed to contact them. Each complaint included an element of miscommunication or misunderstanding, including how patients perceived the manner and attitude of staff.

Divisional staff said they received an average of 12 to 16 complaint per month about medical care services.

Divisional teams used a patient relations report to monitor monthly trends in complaints and PALS concerns including changes in trends, key themes and response timeframes. Where teams took longer than the trust 30-day resolution target, staff involved in the investigation documented reasons for this. Clinical treatment, communication, patient care and staff attitude were the four most common complaint themes and none of the medical wards were outliers for the number of complaints received.

**Is the service well-led?**

**Leadership**

Senior staff used a series of meetings to maintain oversight of their clinical areas and services and to ensure leadership was structured to effectively support their teams. This included monthly ward manager meetings, weekly matron meetings and daily team briefs led by matrons and ward managers. At a divisional level matrons and group managers met formally every week and matrons from all divisions met monthly, with the head of nursing in attendance every other month. The leadership team for each medical specialty, usually a group manager, consultant and matron, met monthly to complement the operational meetings.

Following the completion of a leadership development programme, a group of senior nurses had established an action group. Ward managers chaired the group and the lead nurse for workforce and chief nurse provided support. Nurses established the group to reduce working in isolation and to approach challenges as a team. The group met monthly and invited external speakers to deliver training and talks and had resulted in improvements in how ward managers engaged with the preceptorship programme and student nurses.

Matrons were a visible presence on inpatient wards and in clinical areas. Ward managers and nurses in charge of shifts spoke positively about their relationship with their matron and said they were supportive, communicative and readily available.

An associate director of therapy and heads of service and clinical leads led inpatient therapies services on a day-to-day basis. This included heads of service for nutrition and dietetics; speech and language therapy; physiotherapy, occupational therapy and moving and handling and for podiatry. Clinical leads for physiotherapy and for moving, handling and ergonomics provided senior clinical oversight. Team leaders led individual specialist teams, such as the speech and language therapy team in inpatient medicine.

**Vision and strategy**

The trust had an overarching, well defined vision and strategy that was highly visible throughout the hospital. Staff had access to the details of this on the intranet and senior staff embedded it in meetings and staff engagement exercises.

Ward managers had a demonstrable understanding of their teams and developed a local vision and strategy around their strengths as part of an overall approach to engaging staff in the future of the service. For example, the ward manager on ward 625 had embedded a vision that the ward be
a continually safe and calm environment. We saw this resulted in a high buy-in factor from staff who facilitated a calm and peaceful atmosphere.

In the April 2018 to June 2018 staff survey, 57% of staff said they were aware of trust values and 83% said they saw the five values frequently exhibited in their daily work.

The pain management team were working towards a future service proposal of expansion that would improve education for staff and patients and provision of pain management specialised to local population groups.

**Culture**

Staff in each ward said they felt connected to each other through broad working partnerships within their division and between other divisions. One member of staff said they felt there was, “…a highly developed culture of support” and they felt this was supported by staff at all levels of seniority. A healthcare assistant (HCA) said, “I’ve worked here more than 10 years because it’s a great place to work. The whole team has a great work ethic and everyone is very respectful to each other.” However, one member of staff said, “There’s an expectation of excellence and against that background staff become tired and sometimes move on. Patients are always safe but there’s not enough staff for us to do everything extra the trust wants, we barely even have time for training. I don’t think the managers always understand that because there’s such an overwhelming focus on being the best.”

The leadership team for haematology and oncology had implemented substantial changes to improve the working culture following the departure of a senior nurse and staffing shortages. They provided more consistent senior support on inpatient wards, block booked agency nurses so that they became well known amongst the permanent team, and increased pharmacy cover.

The ward manager on ward 625 fostered a positive experience for management placement students and had developed a range of opportunities to contribute to their development.

Ward 517 had been established as an acute care short-stay ward following a successful trial. While four staff nurses and a long-term locum consultant formed the core team, other staff were provided on rotation from other wards and specialties as a teaching and development tool for them. All of the six members of staff we spoke with were complimentary about the working culture and environment on the ward. One member of staff said, “This is a very pleasant ward to be on. Every day is different, cases are interesting and you can tell the team works well. No-one loses their cool and everyone listens to each other.” The matron empowered more junior staff to challenge decisions they were concerned about or didn’t understand and senior staff respected this and took time to discuss it. We spoke with an HCA about this who told us being able to care for a wide range of patients whilst being able to work closely with senior staff was a key element of why they wanted to stay on the ward. They said, “The doctors tell me why they’re doing things and what it means. It’s a hugely positive part of working on this ward, you’re treated as an equal.”

Allied health professionals (AHPs) described good working relationships with clinical teams across medical areas. For example, a speech and language therapist said they appreciated being able to have critical discussions when there were differences in opinion about policy or practice. They said, “We’re never just told, “This is the way it is”, there’s always a willingness to discuss things.”

Senior AHPs identified a lack of understanding of the challenges to their teams at trust level, which resulted in poor working conditions and an increased risk to patients caused by reduced service levels. For example, staff identified patients living with head and neck cancer frequently presented at the hospital due to gaps in service provision in the community. Although this resulted in a significant increase in demands on therapy teams, senior staff said the trust had not acted on
feedback. One member of staff said, “It’s very disheartening to keep being told, “Just deal with it”, even though we’re so stretched. There’s no drive from a senior level to address the poor care patients get in the community.”

The divisional head of therapies shadowed staff on a monthly basis as part of a structured observation and support programme. This helped to ensure senior staff remained visible and accessible and acted as a continual improvement opportunity for therapists.

Results from a staff survey that collected feedback from April 2018 to June 2018 indicated mixed responses from staff in response to their feelings about the working culture. For example, predominant themes amongst positive comments were that the hospital was a good place to work, staff enjoyed working there and they felt the organisation was caring, welcoming and supportive. However, themes amongst negative comments related to staff perception of the leadership skills of managers and work-related stress. In response the trust developed a leadership development plan for 2018/19 that included five priorities such as improved shadowing opportunities and significantly improved training for managers.

**Governance**

Divisional clinical quality groups led overarching governance through monthly meetings. The groups monitored and reviewed compliance against trust and national guidance, incidents and complaints, progress of risk assessments and a range of other quality and safety processes. The group also reviewed compliance with the duty of candour, internal and action plans and key issues affecting clinical and other divisional services. We reviewed a sample of the minutes of six divisional group meetings for divisions A, C and D that took place from July 2018 to September 2018 and found compliance with duty of candour standards was consistently high and at 100% in all instances with the exception of a 10-day delay in communication in one incident.

Ward managers held monthly quality meetings, which all staff were required to attend. Staff told us the meetings had helped to improve communication and working relationships and senior teams said the meetings had helped to keep momentum during a recent period of change in the trust.

In addition to ward-level processes, clinical governance structures were in place at medical specialty, divisional and trust board level. Divisional preventing harm meetings monitored patient outcomes and risks in all services in the division and the trust equivalent monitored overall outcomes and rolling action plans.

Junior doctors knew how to report shifts that extended beyond their planned time, known as exception reporting.

The guardian of safe working (GSW) and the junior doctors monitoring team monitored exception reporting daily Monday to Friday and directed reports to consultant exception reporting (ER) leads in clinical specialties and departments for action. Junior doctors and local negotiating committees (LNC) representatives scrutinised reports during quarterly guardian exception reporting review group (GERRG) meetings. The trust actively facilitated access to the ER system and gave junior doctors immediate access to the reporting system during their induction. The junior doctors monitoring office maintained oversight of exception reporting over the academic year, which ran from August to July. In 2017/18, junior doctors submitted 125 exception reports, of which the GSW identified five as significant and one that represented an immediate safety risk. Groups responsible for monitoring and clinical governance worked together to stabilise rotas and respond quickly to gaps in planned staffing and consultant ER leads demonstrated continual improvement in the monitoring of working hours. The GERRG monitored rota gaps as part of clinical governance oversight and in July 2018 there were 18 whole time equivalent (WTE) gaps.
The tissue viability team (TVT) utilised a comprehensive clinical audit system and processes to inform understanding of the standards of service. The TVT presented results from regularly scheduled tissue viability quality audits to the care quality group and trust preventing harm group using divisional-level feedback and tissue viability reports.

The project lead for unscheduled care worked with the discharge lounge team to implement an action plan to increase engagement with colleagues across the hospital to improve their understanding of the discharge service and provide opportunities to ask questions. We reviewed the most recent action plan updates, which provided evidence on continuous progress.

Although ward managers found the system for booking bank staff to cover shortages worked well within an embedded governance process, some elements of the system were not well managed. For example, wards with significant permanent nursing shortages were able to offer enhanced pay rates to attract bank staff. This resulted in the wards recruiting over their shift establishment, which consequently resulted in the additional nurses being moved to fill shortages on another ward. This occurred frequently on ward 516 and meant the ward manager either lost permanent nurses with knowledge of the ward or lost bank nurses to a ward that did not offer enhanced pay, which resulted in making the individual less likely to volunteer for shifts. They had implemented a local solution to maintain the morale of bank staff, by paying the difference in hourly rate when they were transferred to another ward. However, this meant they paid for staff without the benefit of having them on the ward. There was limited evidence of a resolution to this at a divisional level.

Governance procedures for Clinical Educators were well established and enabled team leaders within each division to meet regularly to identify opportunities for joint working, learning and projects. A corporate lead nurse educator maintained oversight of the process and meant working between divisions was streamlined whilst allowing Clinical Educators to develop work specific to their specialist medical areas.

AHPs attended monthly clinical team meetings and used these to review complaints, incidents and learning from good practice and areas for improvement.

Senior staff maintained assurance of competence and performance processes for military doctors in the same way they did for NHS doctors. The Military Deanery held accountability for training numbers and doctors were accountable to the Postgraduate Dean for the Defence Deanery who was also their Responsible Officer.

The pain management programme team held a monthly audit and clinical governance that included patient case reviews.

Management of risk, issues and performance

Staff used risk registers to identify, track and resolve risks to their services. Risk registers were maintained at divisional level and service or team level. For example, the division A and division C risk registers included risks appropriate to all services in the divisions or to the division at an operational level. Physiotherapists and other therapies maintained risk registers specific to them, which applied to the care they delivered to specialties within the division. Staff entered risks on more than one risk register where the impact was relevant to both. Divisional leadership teams reviewed and updated their whole register on a quarterly basis. Significant risks in inpatient medical care services included the sustainability of staffing, particularly in older people’s services, and the demand on the system of patients over the age of 65. This was unrelated to dementia and mental health and related to frailty and complex social care needs.
The team on ward 303 had introduced a new handover system to improve communication between staff and ensure the whole team had maintained oversight of risks and operational issues on the ward.

Staff on each ward used an electronic clinical dashboard to monitor patient risk assessments and identify the causes of incidents.

The senior leadership team in division A recognised a key risk for ambulatory care existed when medical patients were admitted there during times of exceptional demand on the service. As ambulatory care did not have a dedicated medical team, there was a risk of delay to treatment if patients were admitted with conditions or dressings the nursing team was unfamiliar with. The senior team mitigated this risk by establishing more defined admission criteria for the unit and implementing the requirement for more robust handovers from ward doctors.

The cardiac arrest team did not provide cover for wards in the east block buildings, which divisional teams recognised as a risk. Resuscitation equipment was located in the main corridor that linked the east block to the main site and the critical care outreach team (CCOT) provided cover for the east block wards as part of the mitigation strategy. The resuscitation lead had implemented a project to explore the feasibility of expanding the cover of the cardiac arrest team to cover all areas.

Each specialty service and division monitored National Reporting and Learning System (NRLS) patient safety alerts for changes to guidance relevant to them. For example, staff in the cardiac catheter lab implemented a closed system for flushing.

We spoke with military and NHS foundation level 1 (FY1) doctors on ward 514 who raised concerns about the differences in rota arrangements between them. For example, they said NHS FY1 doctors worked 14 nights in every four-month period while military doctors worked 22 nights in the same period. They said military FY1 doctors were routinely allocated to FY2 doctor rotas, which meant they help responsibilities greater than their training or experience should allow. Doctors told us they had submitted multiple letters of concern to the medical rota team without a resolution and a complaint to the military deanery was pending an outcome. We discussed this with senior divisional staff who said they were unaware of the practice, which demonstrated gaps in governance and leadership engagement with this staff group. The General Medical Council (GMC) awards provisional registration to FY1 doctors and full registration to FY2 doctors, which meant this situation resulted in military doctors working without appropriate GMC registration.

Senior divisional staff and ward managers used quality dashboards to monitor performance in eight key areas that included safety measures and patient experience. The dashboards were colour-coded using a red, amber, green (RAG) risk-based system that enabled staff to quickly identify areas for immediate action and provided divisional leads with comparable performance data between their areas of responsibility. Ward managers and senior ward nurses acted on inconsistent performance and communicated areas for improvement with their teams. For example, senior nurses on ward 411 identified a drop-in dashboard performance due to challenges with staffing and worked with the teams to implement recovery and continuity strategies. This included implementing more support for agency nurses in submitting data to the dashboard system.

Divisional preventing harm groups met monthly and reviewed clinical governance and departmental performance and risks. We looked at the minutes of meetings that took place in June 2018, July 2018 and September 2018.

Although a sepsis lead was in post and carried out regular audits and reviews, we found limited understanding of this amongst teams in medical care. For example, one matron said the hospital
did not have a sepsis lead and that this was the responsibility of matrons and ward managers. Two CEs told us the infection control team took the lead on sepsis management and that there was no designated lead for this.

Allied health professionals held clinical team meetings every six weeks and monthly performance review meetings. Specialist teams used this time to review staffing and challenges in the service as well as to provide feedback on the service.

Consultants in each specialty led monthly morbidity and mortality (M&M) meetings. We looked at 19 examples of M&M discussions and case review presentations from cardiology, haematology, live transplant, neurology, gastrointestinal medicine and endoscopy. In each case doctors reviewed the patient’s medical history and worked as part of a team to identify opportunities for learning, which they communicated widely to colleagues across services.

Consultants in geriatric medicine implemented monthly M&M meetings as part of a teaching slot for junior doctors working on ward 518 and Bournville, Harborne, Edgbaston, West 1 and West 2 wards. Junior doctors reviewed up to four cases per session as part of a substantive learning programme that reflected the high number of expected deaths amongst the elderly population; this equated to 380 deaths from October 2017 to October 2018.

The quality and outcomes research unit (QuORU) was responsible for developing and overseeing quality metrics for each medical specialty. QuORU operated an intranet site for staff to access audit results, which specialist teams used to monitor patient outcomes.

In response to risks relating to patients with complex needs, the senior team on ward 411 established a managing challenging behaviour group. The head of nursing chaired the group, which contributed to the wider trust mental health group as a clinical governance strategy to manage this risk more effectively. Divisional educators, the rapid assessment, interface and discharge (RAID) team and mental health educators were leading a specialist programme to help improve staff understanding and skills in this topic.

**Information management**

The trust had adapted information availability to meet the NHS Accessible Information Standard. Clinical and IT staff had worked together to ensure staff flagged patient’s needs relating to accessible information on the electronic records system. Detailed guidance was available on the intranet and once staff had logged a patient’s preferences and needs once, all future communications replicated this format. Staff provided information to patients and communicated with them in accordance with their recorded preferences and in line with trust information governance frameworks

The trust had recognised the team on ward 625 with a ‘building healthier lives’ award for information management innovation. Clinical technicians had implemented a system that ensured 100% accuracy in the ordering of blood tests and diagnostics for patients using a barcode scanning system. This offered full information governance assurance and was a significant improvement over previous processes. For example, technicians were unable to order tests without fully and accurately completing electronic data that the system would reject if they did not meet the patient’s personal information.

Clinical quality groups monitored compliance with information governance policy, including the review of any data breaches and current compliance with the General Data Protection Regulations (GDPR) 2016/679. The group reviewed staff training completion in these topics and worked with senior service staff to implement improvements.
**Engagement**

Group managers shared leadership responsibilities with colleagues across divisions to improve communication and coordinate operation of services.

Staff told us senior executives and board members were readily accessible and they felt involved in trust developments.

The senior team on ward 625 had arranged for non-clinical professionals involved in mindfulness, wellbeing and emotional intelligence to provide training sessions for staff to build resilience and provide more enhanced peer support.

Staff readily engaged with organisations outside of the trust to improve patient experience. For example, the team on ward 514 held an annual bake sale and donated the proceeds to stroke non-profit organisations that helped patients recover from strokes.

Senior human resources (HR) staff had facilitated a series of focus groups amongst HCAs to discuss their views on working conditions and wellbeing as a strategy to reduce sickness absence. HCAs reported a high degree of job satisfaction and felt their role was rewarding. However, they also reported they did not always feel valued by more senior staff and that job pressures had a significant negative impact on their health. HCAs also identified a lack of support when they returned to work as a demotivating factor. To address the key issues the HR team worked with the head of inclusion, engagement and wellbeing and the education team to implement a series of changes and improvements to the HCA role. This included more inclusive ward meetings and events to build stronger, more equitable working relationships. The team worked with divisional leaders to ensure they promoted staff assistance schemes more readily and to provide mental health and stress resilience training. Senior staff worked across divisions to identify appropriate signposting for staff to health promotion services such as smoking cessation and alcohol reduction groups, both of which were identified as of benefit during the focus groups.

A staff nurse on ward 625 had developed a welcome workbook for new nurses and HCAs joining them. This included a structured timeline of how their skills would progress as well as details of processes such as daily routines and information on common conditions and complications of the patients typically seen there. The booklet included a list of common abbreviations to help demystify the specialist work of the ward.

Some inpatient wards, such as 411, 516 and 625, produced newsletters for their teams. Contributing staff included items such as a welcome to new starters, details of learning from recent incidents and meetings and future plans. In addition, staff produced a newsletter at divisional level that included a topic of the month, recognition of team achievements and updates on staffing and preventing harm meetings.

Senior nurses on ward 411 had implemented a range of changes and improvements to improve engagement within the team. This included the use of a ward resource folder, daily huddles and a newsletter to embed consistent communication amongst all staff groups. A senior staff nurse mentor team had been established to provide peer support and improved communication dissemination amongst the nursing team.

CEs were working with teams across the hospital to develop a trust initiative of building team skills around human factors. To achieve this, they included human factor discussions in scheduled training and incorporated discussions about human and team behaviour and emotional intelligence in scenario-based simulation training.

The stroke team had produced a video that represented each professional role involved in delivering care.
Senior therapies staff coordinated a trust-wide AHP forum that had expanded to included orthotics, orthoptics and operating department practitioners.

The deputy head of therapies recognised and rewarded staff for excellence in practice. The senior team also recognised the impact on staff of expansion in the service and offered mindfulness and resilience training and more frequent supervision.

Division C had actively engaged with adult social care nurses who worked in the community through open days designed to help make the hospital an attractive place to work. Senior staff had found community nurses were often mystified or intimidated by the hospital environment and used the open days to generate interest as part of a wider recruitment strategy.

Division C had established a steering group for reward and recognition, which also operated as a staff retention group. This group recognised staff with an awards and rewards programme and offered career development advice as a strategy to keep staff motivated.

Heads of therapies had led a series of listening events in 2017 following staff survey results. They subsequently implemented a two-year action plan and periodic away days for therapists to improve engagement and team working opportunities away from patient contact time.

The trust implemented a quarterly staff survey from April 2018 following an acquisition process that saw the Queen Elizabeth Hospital merge into a large trust with other hospitals. In the first survey, from April 2018 to June 2018, 78% of staff in this hospital said they would recommend it as a place to work and 92% said they would recommend the hospital as a place for treatment.

In September 2018 the executive team implemented a more interactive approach to engagement with senior divisional staff, including the opportunity to submit anonymous questions from staff in advance of monthly briefings.

Clinical services maintained consistent standards of communication with colleagues who used their services. For example, the pathology service issued informative newsletters to keep staff up to date on an innovative project to develop a single pathology pathway using a hub model.

Staff had established three networks to help promote visibility and reduce stigma of diverse or minority groups and the trust supported access to each as groups independent of governance or divisional teams. The lesbian, gay, bisexual and transgender (LGBT) network was working towards accreditation by the Stonewall Workplace Equality Index, had established a trans policy working group and planned and facilitated a sexual orientation and gender identity conference. The black and minority ethnic (BAME) staff network was working with the trust to establish a workforce race equality standard and had worked to establish celebrations and events for black history month. Staff in the disability network were committed to the delivery of the disability confidence scheme and worked with divisional staff to advise on work policies that impacted its members.

A project team had led a junior doctors workforce review to understand the service they provided and the challenges they face. This was an in-depth engagement exercise to strategise improved ways of working and communicating and involved focus groups, one-to-one discussions, drop-in sessions and online sessions. As a result, the hospital appointed a dedicated junior doctor engagement manager to continue engagement.

A dedicated culture and workforce project group was established to deliver an engagement and communication plan to keep staff informed during the acquisition of the hospital with another trust.

Staff acted on feedback from patients and relatives to improve the service. For example, the team on ward 411 were working with the trust’s charitable team to convert a day room into a sensory
room. This followed feedback that the ward was too noisy by patients who needed peace and quiet to recover. The team on ward West 2 worked with facilities colleagues to improve signage in the building and to facilitate better out of hours access for relatives visiting patients who were acutely unwell or receiving palliative care.

**Learning, continuous improvement and innovation**

A service innovation team supported staff to develop projects and initiatives that promoted development and improvement in their specialty. The team facilitated use of a service improvement toolkit and provided staff with access to specialist development courses on managing teams through change.

Staff had access to management and leadership training courses to help improve development and retention.

The tissue viability team ensured their service was led by the latest research outcomes and best practice standards updates. They maintained a journal club to support colleagues across the hospital in keep abreast of the latest knowledge in the specialty.

The acute rehabilitation team was carrying out research into the length of stay on wards and was due to present their findings to date at an annual trust congress that showcased innovative work.

As part of capacity and service continuity planning for the 2018/19 winter pressures period, matrons planned to implement a modified working hours trial from November 2018. This meant shift patterns would be changed to include longer days planned to offer more support to junior nurses.

Senior division A staff had visited discharge suites in other hospital trusts to identify areas of good practice that could be used to improve the service.

Service contingency plans were in place for the 2018/19 winter pressures period. This included opening a second discharge suite and staffing it by assigning nurses and HCAs on bank shifts who were permanent staff elsewhere in the hospital. The ambulatory care unit operated a seven-day service during this period. The senior division A team said this had worked well in the 2017/18 winter period and staff had readily volunteered to work in both areas. This contributed significantly to a reduction in bed blocks in inpatient wards.

Senior divisional staff were demonstrably focused on future planning for their services and workforce. For example, the division A leadership team were projecting how their nursing and AHP workforce would develop in the next 10 years and what they needed to do to adapt and support.

Staff on ward 516 used an electronic access system that greatly reduced the time nurses traditionally spent looking for keys for cupboards used for medicines and equipment. The system involved electronic programmable key access, with nurses signing out a key at the beginning of each shift. This would enabled them to access items commensurate with their role and responsibilities and provided security assurance for controlled drugs (CDs) access. For example, two separate programmable keys were required to access CDs. This meant that someone with a single lost key could not access restricted items.

AHPs had been nominated for 15 building healthier lives awards including recognition for sports medicine services.

AHPs engaged in substantial research and development programmes based on trends in patient demand. For example, physiotherapists and occupational therapists in upper limb therapy had successfully recruited a senior research therapist. Therapists had implemented a four-year research plan in sarcopenia, a condition related to old age and frailty, and three therapists were
undertaking research-based masters study. Two therapists were doctoral (PhD) candidates and research nurses worked closely with the team to develop the research programme. Senior therapies staff recognised the impact of the interest and involvement in research and were establishing clinical academic posts with protected time for research, which would address national findings from the Council of Deans for Allied Health Professionals that AHPs lack time for research. A therapy research and education group established a series of drop-in sessions that enabled staff of all grades to discuss their ideas for research and audit.

A multidisciplinary team, including AHPs, matrons and service managers were leading a three-month project with two inpatient wards to identify how clinical pathways and relationships with community providers could be improved to reduce length of stay. The project team had identified that patients could wait up to two weeks for a therapist review in their home despite being medically fit. To address this the team was establishing closer working relationships with the hospital’s recovery at home team, who provided up to six days’ service following discharge. The project had resulted in 100 saved bed days that would otherwise have been used waiting for community care plans.

Senior therapies staff had established working groups with higher education partners to help plan future recruitment following gaps in the usual provision from Health Education England. This meant the team used developing local relationships to plan continual recruitment from therapists trained specifically for the acute environment. The team also shared attrition rates with other hospitals across the west Midlands as part of a strategy to keep talent in the region.
Surgery

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

A breakdown of the surgical service for Queen Elizabeth Hospital can be seen below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital Birmingham</td>
<td>Admissions lounge</td>
<td>Elective surgical admissions</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Ambulatory care services</td>
<td>Day case and short stay surgery</td>
<td>81 trolleys</td>
</tr>
<tr>
<td></td>
<td>Anaesthetics</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Theatres</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Ward 305</td>
<td>General surgery/vascular surgery</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 306</td>
<td>Cardiac surgery</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 409</td>
<td>Neurosurgery</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 410</td>
<td>Trauma</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 412</td>
<td>Trauma</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 620</td>
<td>Surgical assessment unit</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 624</td>
<td>Urology/ENT/MaxFax/plastics</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td><strong>Total beds</strong></td>
<td></td>
<td><strong>252</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The surgical service at Queen Elizabeth Hospital comes under two of the trust’s divisions and has senior matrons, matrons, ward managers, two divisional directors, two directors of operations and two heads of nursing.

Within the trust, Good Hope Hospital, Birmingham Heartlands Hospital and Solihull Hospital also provide surgical services.

The trust provides two nationally commissioned transplant programmes:
- Heart / lung
- Liver

(Source: Acute Provider Information Request – Context acute tabs)
Surgical admissions

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust had 46,812 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 14,392 (30.7%), 23,026 (49.2%) were day case, and the remaining 9,394 (20.1%) were elective.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust had 59,370 surgical admissions from April 2017 to March 2018. Emergency admissions accounted for 19,116 (32.2%), 33,370 (56.2%) were day case, and the remaining 6,884 (11.6%) were elective.

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it. We saw that for theatres and surgical wards, staff had either completed the required training or was scheduled to attend training sessions in any subjects they needed training in.

Training was made readily available to all staff. We spoke with a matron, a nurse in charge, a physiotherapist and an occupational therapist about how training was managed. All staff accessed the trust intranet and used a portal called “Me at QHB” to manage their training. Staff saw when training was out of date as an amber warning appeared on the portal. Managers coordinated staff training using a central dashboard accessed through the electronic system.

Staff accessed online training and attended face to face training on training days. The trust provided training days for courses such as manual handling and cardiopulmonary resuscitation (CPR) and basic life support. In addition to the topics listed in the tables, staff received training in sepsis management, safeguarding, mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). A member of staff from the infection prevention and control team told us that the team provided face to face mandatory update training for all staff. They said they trained around 30 to 40 staff a month.

Therapy staff such as physiotherapists and occupational therapists had their own training programme, including face to face training on X-ray and imaging, hip fractures and peripheral nerve injuries.

The table below shows from April 2017 to March 2018, in surgery, the hospital had an overall mandatory training compliance rate of 94.2% for qualified nursing staff. The trust’s training targets were met for six of the seven mandatory training modules for which qualified nursing staff were eligible. The manual handling module had the lowest completion rate, at 84.5%.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate induction</td>
<td>53</td>
<td>53</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major incident planning</td>
<td>644</td>
<td>644</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>617</td>
<td>645</td>
<td>95.7%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>615</td>
<td>645</td>
<td>95.3%</td>
<td>95.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire training</td>
<td>608</td>
<td>644</td>
<td>94.4%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>313</td>
<td>346</td>
<td>90.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling</td>
<td>399</td>
<td>472</td>
<td>84.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The table below shows that for medical staff the division did not meet the trust target in most subjects. However, we carried out checks on training with the surgery department on site and found that staff had completed required training or were scheduled to do so.

From April 2017 to March 2018, in surgery, the hospital had an overall training compliance rate of 81.1% for medical staff. The trust’s training targets was met for one of the five mandatory training modules for which medical staff were eligible. Corporate induction had a completion rate of only 64%.
<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident planning</td>
<td>529</td>
</tr>
<tr>
<td>Information governance</td>
<td>419</td>
</tr>
<tr>
<td>Infection control</td>
<td>405</td>
</tr>
<tr>
<td>Fire training</td>
<td>398</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>100</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

The service managed training effectively at a local level to make sure staff received the learning they needed to do their jobs. We saw that matrons managed training locally using their own logs of staff training. A matron showed us a log where they had recorded competency checks for new staff to ensure they were competent. We saw that this was also done for temporary staff.

The Corporate Induction Policy, last reviewed June 2017, stated the recruitment team booked new staff onto the corporate induction through the online learning management system (LMS) once they completed all pre-employment checks.

Health Education West Midlands (HEWM) recruited trainee doctors on rotation on behalf of the Trust. HEWM notified the trust of new doctors’ details and start dates. The medical workforce team booked trainee doctors onto the corporate induction and informed them of the need to complete their pre-start induction online training within the first two weeks of commencing employment. The trust issued locum doctors supplied by external agencies with an on-line copy of the locum induction booklet. Bank staff attended the corporate induction programme if they had not worked at the trust in the last 13 months. Temporary agency staff received a local induction in their department. An agency nurse told us their induction was for one week when they started work at the trust.

All members of staff received a local Induction during their first week of work. This was the responsibility of their line manager to arrange and oversee.

**Safeguarding**

Staff had training on how to recognise and report abuse and they knew how to apply it. We saw that matrons managed safeguarding in each area and staff had received training. Staff who were due for training were scheduled to attend the training.

The trusts 2017/2018 safeguarding annual report stated there was a combined approach to safeguarding adult and child learning and development at levels 1 and 2. The training made it clear that the statutory frameworks for responding to child and adult safeguarding concerns were separate. The report stated that 86% of the 275 bank staff were compliant with safeguarding level 2 for adults and children. The trust provided level 1 training to all volunteers which was updated every three years. The trust planned in the next year to review level 2 for safeguarding adults and children and to continue to promote in house domestic abuse training to educate staff about domestic abuse.

The report also stated that in November 2017 the trust hosted a safeguarding adult conference across sites and there were 300 attendees. The conference was supported by internal and external speakers and included input from Women’s Aid, BLGBT (Birmingham Lesbian, Gay, Bisexual and Trans), HALO (honour based violence, forced marriage). RSVP (Rape and Sexual Violence Project). The conference included a talk from a survivor of abuse. The trust planned to
run a further safeguarding adult conference across three sites in November 2018 with focus on ‘True Partnership Working’. The sessions were fully booked.

The safeguarding team carried out ‘walkarounds’ to clinical areas to confirm that frontline staff knew how to identify a safeguarding need, who to contact if they had a safeguarding concern and where to access safeguarding policies.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. We spoke with four members of staff who confirmed they had attended safeguarding training and were happy to raise concerns if necessary. We spoke with a matron and looked at a patient record where staff had referred the patient to safeguarding, to protect them from abuse and ensure partnership working.

The trust had a safeguarding adult policy, this was accessible to staff through the trust intranet. We saw displays in wards and departments, raising the awareness of safeguarding and action to take if required.

The intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014) states all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should be trained to level two.

The table below shows safeguarding training rates from April 2017 to March 2018 for qualified nursing staff in surgery at Queen Elizabeth Hospital.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1</td>
<td>644</td>
</tr>
<tr>
<td>Safeguarding level 2/ DOLs and mental capacity</td>
<td>545</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall safeguarding training compliance rate of 97.2% for qualified nursing staff. The trust’s 90% completion target was met for both safeguarding training modules.

The table below shows safeguarding training rates from April 2017 to March 2018 for medical staff in surgery at Queen Elizabeth Hospital.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1</td>
<td>529</td>
</tr>
<tr>
<td>Safeguarding level 2/ DOLs and mental capacity</td>
<td>149</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall safeguarding training compliance rate of 90.8% for medical staff. The trust’s 90% completion target was met for one of the safeguarding training modules for which medical staff were eligible. The level two training had a completion rate by medical staff of 68.3% which was much lower than the trust target of 90%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Cleanliness, infection control and hygiene**
The surgical service controlled infection risk well. Preoperative assessment staff screened patients using comprehensive questionnaires and interviews and swabs for a range of potential infection risks. This included methicillin-resistant staphylococcus aureus (MRSA), methicillin-susceptible Staphylococcus aureus (MSSA) and contact with infections such as tuberculosis (TB) influenza (Flu) and clostridium difficile (C.diff).

We found that staff kept the theatres and wards clean and free of clutter. We saw that staff stored equipment and dirty laundry away from corridors and patient areas.

Staff followed robust cleaning schedules. In theatres, staff completed thorough infection prevention and control audit checklists for each month to ensure areas were clean and guidance had been followed. We saw staff used an “infection control audit tool for theatres” to carry out checks on hand hygiene, clinical practice, sharps handling, waste disposal and decontamination of equipment and environment. Audits showed good results for theatres. Staff followed procedures to ensure surgical instruments were decontaminated. We saw staff followed infection prevention and control practices before, during and after surgery. We observed staff handwashing, using hand sanitising gel and wearing appropriate surgical scrubs. We saw the trust had invested in covers for surgical equipment stored in corridors to promote infection control.

On the surgical wards there was a housekeeper for each ward who ensured areas were clear and tidy. We spoke with a domestic team leader who said that the facilities department carried out a thorough cleanliness audit of each ward every three months. The audit results for July to September 2018 showed good results of over 80% for the surgical service, including theatres and wards. We saw that domestic staff had completed a list of cleaning tasks in the domestic folder on each ward. This ensured that when domestic staff were on leave, other staff could follow the list of required tasks.

Staff were clear about their responsibilities for infection control. Staff accessed infection prevention and control policies and procedures on the trust’s intranet. We observed staff used handwashing facilities and hand sanitising gel when caring for patients and moving between clinical areas. Staff followed guidance on being bare below the elbows and not wearing jewellery such as jewelled rings and watches.

We spoke with an infection prevention and control (IPC) lead for the surgical service. They said that they carried out observations of staff interactions with patients on their daily ward rounds to check for infection control practice. IPC link nurses on wards carried out daily hand hygiene audits and submitted them to the IPC team. We saw the hand hygiene audit results for April to September 2018 were good at over 88% for the surgical Division B and Division D. The IPC team held link nurse sessions every six to eight weeks to discuss issues and provide advice and training. The IPC team held monthly face to face training sessions for staff and held an additional event for housekeeping staff.

The IPC team attended the wards if a patient had a suspected or actual infection to provide support to prevent the spread of infection. The IPC team held a post infection review meeting with staff to prevent future incidents.

Surgical site infection rates for the trust for April 2016 to March 2017 were 0.7% for repair of neck of femur fractures (lower than the England average) and 2.7% for hip replacement (higher than the England average). The last England average stated in the Public Health England Surveillance of Surgical Site Infections April 2016 to March 2017 was 1% for repair of neck of femur and 0.9% for hip replacement.

In the Patient-Led Assessments of the Care Environment (PLACE) audit for 2018, the trust had a score of 99.74% for cleanliness. This was above the England average of 98.5%.
The trust’s IPC annual report 2016/2017 stated that it had been a challenging year with national objectives for Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.diff) infection aimed at delivering a zero tolerance approach to avoidable infections. The trust had a decrease in MRSA and other healthcare-associated infection compared to the previous year.

During 2016 and 2017, there were staff changes within the infection prevention and control team including the appointment of a new lead doctor and a new lead nurse.

For the period 1 April 2016 to 31 March 2017 there were four cases of hospital acquired MRSA and 92 cases of hospital acquired C.diff. for the whole trust. This was a rate of 22.7 cases per 100,000 bed days which was higher than the trust target of 17.3 cases per 100,000 beds. In the trust’s Infection prevention and control annual report 2016/2017 the trust reported that it had a MRSA reduction plan and a C.diff action plan to reduce the occurrence of both infections.

The trust had a trust antibiotic committee (TAC) which was chaired by a Public Health England (PHE) consultant microbiologist. The trust had a pharmacist at the hospital to ensure that antibiotics were used effectively (antibiotic stewardship).

Environment and equipment

The service had suitable premises and equipment and looked after them well. We saw that the theatres and surgical wards were tidy and well equipped. Equipment we looked at had been cleaned and tested for electrical safety.

We saw that staff used an “environment audit dashboard” for all areas of the service to monitor results of checks on the environment. We saw that staff completed an audit of the environment across wards every three months. All results were shown as green and amber, which showed that all areas of the surgical service had at least an 80% compliance score between September 2017 and July 2018. We saw staff had labelled equipment in theatres to show when it required servicing. Equipment we checked was in date for servicing.

We saw staff had correctly stored cleaning equipment and substances hazardous to health (COSH). Surgical wards had a housekeeper who had oversight of the environment and worked closely with domestic staff. This ensured areas were kept tidy and equipment was stored correctly.

Equipment for larger patients was available. We spoke with a nurse in theatres who explained they had recently invested in equipment for bariatric patients during surgery. We saw in pre-assessment, the admissions lounge for day surgery and on wards chairs and beds were available for larger patients.

Overall, across the surgical service staff recorded checks of equipment. However, we saw in one theatre staff had not completed full checks of the anaesthetic machine. We raised this with staff who said checks had been done but were not always written down.

We saw in the ambulatory day surgery unit, there were omissions in the checks of the resuscitation equipment. A member of staff had written a note on the log that if the unit is closed, staff should write “unit closed” to prevent any gaps. We saw that staff had recorded checks of resuscitation equipment on the surgical wards.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Staff carried out robust pre-assessment screening of patients who needed surgery. This was documented in an assessment form on the electronic system (PICS) which included patient medical history and questions about medication and exercise...
tolerance. Staff also asked patients about social needs after surgery to help the service to plan the patient’s discharge from hospital.

We observed a patient in the pre-assessment clinic. Staff completed checks of the patient’s blood pressure, urine, heart rate and tested for infections. Anaesthetists ran clinics four days a week and saw patients with additional medical concerns to assess them for surgery. Medical concerns included heart conditions, abnormal heart monitoring results and sleep conditions.

Staff could carry out a telephone pre-assessment with patients to save their time coming into hospital. The consultant identified suitable low risk patients when they were booked in for pre-assessment. This meant that staff could screen more patients in a week. A member of staff told us they did telephone assessments on an ad hoc basis but was particularly helpful for patients who lived further away, such as those in the military.

On surgical wards, staff completed risk assessments for patients and used the PICS system to log these. These included the malnutrition universal screening tool (MUST), body map and pressure ulcer risk (Waterlow), falls risk and mental capacity.

Nursing staff used an early warning system, based on the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores enabled early recognition of a patient deterioration by grading the observations and prompting nursing or medical reviews at specific trigger points. We reviewed seven patient records and saw that the NEWS assessment had been carried out. We saw in the seven patient records that staff had carried out risk assessments for Venous thromboembolism (VTE), a condition where a blood clot forms in a vein. This meant staff could ensure patients at risk could be given preventative measures such as special leg stockings and medication.

The service had systems in place to ensure staff identified and treated sepsis within an hour as recommended by the sepsis six guidelines developed by the UK Sepsis Trust. The trust had a protocol for sepsis recognition and treatment. If staff suspected a patient had an infection, they spoke with a senior doctor. Staff treated the patient for Sepsis if one “red criteria” warning sign was present. Staff used a “Sepsis 6 bundle” which helped them to decide the treatment for each patient. We spoke with two staff about who said they were aware of early recognition of sepsis and knew the protocol. The trust had introduced an antibiotic bleep to improve timescales for urgent administration of antibiotics in patients with sepsis. This meant a pharmacist was on call to administer antibiotics to patients when needed.

Senior leaders for surgery told us the trust had a microbiologist who was the lead for sepsis and a dedicated pharmacist for sepsis. They said that staff would report on the incident reporting system if staff had not given antibiotics to a patient with sepsis within an hour. This would be classed as moderate harm and would be investigated by the sepsis team.

In the operating department, we observed staff used the world health organisation (WHO) surgical safety checklist. The WHO is a simple checklist developed by the World Health Organisation, which reduces surgical risk through a series of checks on the patient's identity, operation site, procedure and consent. It also included identification and dedicated role of all staff present. We followed a patient through theatre and noted all checks were completed appropriately.

The operating department complied with the five steps to safer surgery as recommended by the national patient safety agency (NPSA) 2010. This includes; team briefing, sign in, time out, sign out and debriefing. The aim of the five steps to safer surgery was for teams to work collaboratively together to ensure patient safety.
Overall in theatres we observed staff followed guidelines, policies and best practice. However, we saw two instances where staff did not follow best practice. We observed dental extraction surgery and saw that staff completed the oscillating tip saw instrument checklist post-operative signature at the start of the operation. This is not good practice. We observed ophthalmic surgery and saw on one occasion a surgeon collected the implant but staff did not sign out the implant. In this case staff did not follow the WHO surgical safety checklist.

The service had developed Local Safety Standards for Invasive Procedures (LocSSIPs) but the service had not yet put these into practice. We asked staff about the National Safety Standards for Invasive Procedures (NatSSIPs). We spoke with a member of staff in theatres who said there were working groups across the trust’s hospital sites to talk about safety standards and procedures. Two theatre staff we spoke with had not seen any guidance for staff around the associated Local Safety Standards for Invasive Procedures (LocSSIPs). Senior leaders for surgery told us the service’s LocSSIPs lead had produced local safety standards but these awaiting sign off at senior level and to be put into practice in the next few months.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. We observed staffing across the surgical service. Theatres were staffed in line with the recommendations of the Association for Peri-operative Practice (AfPP). We found that staffing was adequate across the service to provide safe care for patients. However, several of the surgical wards were one staff nurse less than the planned number in the day and at night.

We spoke with two matrons who said the matrons worked together to cover staffing across the surgical divisions using a central electronic staffing system. They said that there had been a shortage of staff over the last few months which had been difficult but they had pulled together to prevent any impact on patients. Matrons reviewed staffing three times a day. They said they covered shifts using their own staff as much as possible. Nursing staff worked shifts as bank staff between their rostered shifts.

We spoke with nursing staff who told us that there had been difficulty with staffing in the last few months but that this had improved. We spoke with a matron and ward manager who said that it was always challenging to fill the rota with qualified nurses and recruitment was difficult due to the speciality of the surgical service. They said staff manage the risks by moving high dependency beds between surgical wards to spread the patient care between wards according to staffing. Nursing staff told us they were having to work very hard to maintain the level of patient care.

We observed health care assistants would often be required to support patients with additional needs on a one to one basis. Where this was not possible due to staffing, staff placed patients who required additional support in one bay and a healthcare assistant would support two or three patients.

Senior managers for the service told us they were trying to use creative ways to manage staffing. On one ward we saw that the service had changed the planned staffing from six qualified nurses and four health care assistants to five qualified nurses and five health care assistants to support the needs of patients requiring additional support and to enable rotas to be filled. The service had recently recruited nursing staff who were due to start in January 2019. On some wards new nurses had started work but were still training for and so were not caring for patients alone. Staff told us they were positive staffing will improve in the next few of months.

The table below shows the trust’s nursing staffing numbers for surgery for March 2018 and June 2018. The overall fill rate for qualified nursing staff dropped from 87.4% in March 2018 to 74.8%
in June 2018.

The staffing data for June 2018 for Queen Elizabeth hospital shows a drop of to only 0.8 members of qualified nursing and midwifery staff. This has been queried with the trust.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>1,199.7</td>
<td>1,268.6 94.6%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>291.9</td>
<td>399.7 73.0%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>79.5</td>
<td>111.3 71.4%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>163.3</td>
<td>203.9 80.1%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Vacancy rates

The trust was unable to provide the appropriate data.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 8.7% for qualified nursing staff in surgery. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 2.8%
- Birmingham Heartlands Hospital: 20.4%
- Good Hope Hospital: 12.9%
- Solihull Hospital: 14.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 5.0% for qualified nursing staff in surgery. This is above the trust targets of 3.6% for Queen Elizabeth Hospital, and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

- Queen Elizabeth Hospital: 5.7%
- Birmingham Heartlands Hospital: 3.6%
- Good Hope Hospital: 5.0%
- Solihull Hospital: 4.8%
**Bank and agency staff usage**

From April 2017 to March 2018 the trust reported 5,841 shifts were filled by agency staff, 40,015 by bank staff and 23,539 shifts were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>2,468</td>
<td>34,240</td>
<td>19,211</td>
</tr>
<tr>
<td>Other sites</td>
<td>3,373</td>
<td>5,775</td>
<td>4,328</td>
</tr>
</tbody>
</table>

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Consultants carried out a daily ward rounds and saw each patient. Consultants carried out ward rounds at weekends and saw all emergency patients and other patients requiring consultant review.

Senior managers told us the junior medical workforce was stretched but had used creative ways to staff the service. The service employed Physician Associates (PAs) in most specialities to support junior doctors. PAs stayed with specialities for long periods of time which meant there was consistency in staffing.

The trust has reported its staffing numbers below for March 2018 and June 2018 for medical staff in surgery.

The overall fill rate for medical staff dropped from 94.9% in March 2018 to 90.9% in June 2018. Solihull Hospital has a particularly low rate, with only one member of staff in post out of a planned five in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018 Actual staff – WTE in month</th>
<th>March 2018 Planned staff – WTE</th>
<th>March 2018 Fill Rate</th>
<th>June 2018 Actual staff – WTE in month</th>
<th>June 2018 Planned staff – WTE</th>
<th>June 2018 Fill Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>586.6</td>
<td>556.3</td>
<td>105.5%</td>
<td>774.6</td>
<td>805.2</td>
<td>96.2%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>254.9</td>
<td>335.0</td>
<td>76.1%</td>
<td>256.0</td>
<td>350.7</td>
<td>73.0%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>102.0</td>
<td>100.0</td>
<td>102.1%</td>
<td>100.0</td>
<td>95.8</td>
<td>104.5%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>1.0</td>
<td>4.0</td>
<td>25.0%</td>
<td>1.0</td>
<td>5.0</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

**Vacancy rates**

The trust was unable to provide the appropriate data.

**Turnover rates**

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
From April 2017 to March 2018, the trust reported a turnover rate of 7.0% for medical staff in surgery. This is below the trust target of 8.5% for Birmingham Heartlands Hospital and Good Hope Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 4.6%
- Birmingham Heartlands Hospital: 9.5%
- Good Hope Hospital: 15.5%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 1.1% for medical staff in surgery. This is below the trust targets of 3.6% for Queen Elizabeth Hospital, and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and their community locations.

A breakdown by site is below:

- Queen Elizabeth Hospital: 1.0%
- Birmingham Heartlands Hospital: 1.4%
- Good Hope Hospital: 0.6%
- Solihull Hospital: 9.1%

The rate for Solihull is above the target of 4.0% for this site, but relates to a small number of staff.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Locum and agency staff usage**

From April 2017 to March 2018 the trust reported that 10,444 shifts were filled by agency medical staff, 8,034 by locum medical staff and that 1,292 were left unfilled.

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>4,831</td>
<td>1,736</td>
<td>747</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>3,948</td>
<td>2,969</td>
<td>386</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>936</td>
<td>2,425</td>
<td>105</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>729</td>
<td>904</td>
<td>54</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

In May 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

**Staffing skill mix for the whole time equivalent staff working at University Hospitals Birmingham NHS Foundation Trust**

| This | England |
Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Staff completed patient records in electronic format on the PICS system and in paper format stored in lockable cabinets on the wards. Staff also completed a daily record of care provided to patients which was kept at the end of each patient’s bed.

We reviewed nine sets of patient notes, including the electronic PICS record, the paper medical notes and the paper end of bed care record. Staff had completed these fully and information was filed in a logical order. Written statements were signed and dated. There was documentary evidence of relevant communication with other health professionals.

We saw records included required documentation for risk assessments including falls risk assessment, pain management, pressure care risk assessment and the malnutrition universal screening tool’ (MUST).

We saw one patient’s record who was ‘end of life’ and required do not attempt cardio pulmonary resuscitation (DNACPR) documentation. There was evidence of discussions with the patient’s family member in making decisions.

In Pre-assessment staff used an electronic system to manage patient bookings. Staff could also use the system to view any letters consultants sent to patients about their surgery. Pre-assessment checks on patients were recorded in the PICS electronic patient record.

When staff discharged a patient, they sent a fax to the patients’ G.P. and gave a printed copy to the patient.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Staff stored all medicines, including intravenous fluids securely on all wards visited. Staff administered medicines as prescribed to patients with few omitted doses. All controlled drugs were stored in locked cupboards and required two nurses to access them.

Staff completed VTE (venous thromboembolism) assessments for all patients and recorded patient allergies.
Staff gave patients the right medication at the right dose at the right time. Staff completed checks on medicines they administered against the patient records to ensure staff gave them correctly. We reviewed 19 prescription charts and found staff used the PIC system to record medicines given. Staff scanned the patient’s wristband which identified the patient on the PIC system. Staff used log in details which identified them on the PIC system which recorded they had given the patient the medicine. If staff had omitted a dose of medicine, a note came up on the system to show which member of staff was logged on at the time. The record was also shown as green on the system to highlight the gap.

We saw on the PIC system staff had carried out checks to ensure the right medicine had been given to patients. The system displayed a green cross where staff had carried out checks.

The surgical ward housekeepers placed a weekly stock order which had next day delivery. Night staff carried out daily medicine stock checks and senior nurses checked the medicines stock each week.

Staff recorded fridge maximum and minimum temperatures to ensure medicines were stored correctly. We saw records of actual temperatures that showed the fridges operated at acceptable temperatures.

Pharmacy technicians worked on surgical wards. This meant that patients did not have to wait for medicines and discharges were not delayed. TTO’s (medicines to take out) were available for patients when they were ready for discharge.

Overall, across the surgical service staff recorded fridge temperature checks and checks of equipment. However, we saw in one theatre staff had not completed full records of fridge temperatures or full checks of the anaesthetic machine. We raised this with staff who said checks had been done but were not always written down.

**Incidents**

The service managed patient safety incidents well. Staff reported incidents using an electronic reporting system which staff told us they could access and complete. Staff copied matrons in to any incident entries so they could monitor actions.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. We discussed learning from incidents with two matrons on the surgical wards. They told us that staff in the ward risk team held regular meetings held at least once a month where incidents and complaints were discussed. The ward manager decided the level of risk for each incident and escalated more serious incidents to the matron. The matron looked at all incidents and asked the ward manager for updates where required. Staff updated the incident electronically to show the actions that had been taken. A member of staff told us that they received an update electronically when they had reported an incident.

Ward managers completed a route cause analysis report and an action plan after each serious incident. They said they would talk to the staff involved about the learning from the incident.

The deputy head of nursing held monthly “preventing harm” meetings with matrons to discuss learning from incidents across wards. A matron we spoke with said process had improved over recent years and was managed well.

When things went wrong, staff apologised and gave patients honest information and suitable support. A matron we spoke with confirmed when they investigated complaints they followed Duty of Candour guidance to keep family members informed of actions the trust was taking following the complaint.
The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person.

**Never Events**

There were three reported never events for surgery at Queen Elizabeth Hospital in the twelve months August 2017 to July 2018. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From August 2017 to July 2018, the trust reported four incidents classified as never events for surgery:

- Wrong site surgery in October 2017 at Queen Elizabeth Hospital
- Wrong site surgery in November 2017 at Queen Elizabeth Hospital
- Wrong site surgery in April 2018 at Queen Elizabeth Hospital
- Retained foreign object in April 2018 at Good Hope Hospital

*(Source: Strategic Executive Information System (STEIS))*

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust reported one incident classified as a never event for surgery. This related to wrong site surgery and occurred at Birmingham Heartlands Hospital in October 2017.

**Serious Incidents reported through STEIS**

There were 23 reported serious incidents for surgery at Queen Elizabeth Hospital in the twelve months August 2017 to July 2018.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 33 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England occurring from August 2017 to July 2018.
The breakdown by type of incident reported were:

- Surgical/invasive procedure incident with 11 (33.3% of total incidents)
- Slips/trips/falls with six (18.2% of total incidents)
- Pressure ulcer with five (15.2% of total incidents)
- HCAI/Infection control incident with five (15.2% of total incidents)
- Diagnostic incident including delay with two (6.1% of total incidents)
- Medication incident with two (6.1% of total incidents)
- Sub-optimal care of the deteriorating patient with one (3.0% of total incidents)
- Treatment delay with one (3.0% of total incidents)

Site specific information can be found below:

- Queen Elizabeth Hospital (August 2017 to July 2018): 23 incidents
- Birmingham Heartlands Hospital (April to July 2018): seven incidents
- Good Hope Hospital (April to July 2018): two incidents
- Solihull Hospital (April to July 2018): one incident

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2017 to March 2018.
The breakdown by type of incident reported were:

- Pressure ulcer with eight (34.8% of total incidents)
- Slips/trips/falls with six (26.1% of total incidents)
- Surgical/invasive procedure incident with three (13.0% of total incidents)
- Sub-optimal care of the deteriorating patient with two (8.7% of total incidents)
- Diagnostic incident including delay with two (8.7% of total incidents)
- HCAI/infection control incident with two (8.7% of total incidents)

Site specific information can be found below:

- Birmingham Heartlands Hospital: 13 incidents
- Good Hope Hospital: eight incidents
- Solihull Hospital: two incidents

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place once a month and the trust must submit the data within 10 days of the suggested data collection date.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services as all incidents were reported under the core service ‘Other’.
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported 50 new pressure ulcers, eight falls with harm and two new catheter urinary tract infections from August 2017 to August 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Heart of England NHS Foundation Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Please note that this includes data for April to June 2018 which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.

(Source: NHS Digital)

The service used safety monitoring results well. Staff collected safety information which was shown on a “clinical dashboard” on the electronic PIC system. Staff collected information such as the number of patient infections for example, methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile (C.diff) there had been. The dashboard also showed the number of patients falls and the number of pressure sores patients had developed in hospital. Staff could view this information for each ward.

The service used information to improve the service. A ward manager told us they analysed information on the dashboard and raised any issues with staff both face to face and by email. The
ward manager said they also celebrated as a ward when there had been an improvement in patient safety figures.

The trust had an emergency preparedness policy and major incident plan which included responsibilities for specific roles. Senior managers knew what was required of them in a major incident situation. Senior managers for the service told us the trust was a leader in major incident planning and had developed a triage system for disaster planning that was due to go live soon. The trust had carried out this work with NHS England and the World Health Organisation.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. We found managers checked to make sure staff followed guidance. The service followed national guidance including National Institute for Health and Care Excellence (NICE), Royal College of Surgeons (RCC) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The service supported staff to follow the national guidelines as it had local guidelines and policies. The trust measured compliance with the national standards through local and national audits and through presentation to the clinical governance meetings.

Staff had access to the trust intranet where all policies, protocols and procedures were stored. Each speciality had monthly multidisciplinary meetings attended by physiotherapists, occupational therapists and nurses. The service used the meetings to review its effectiveness and plan actions to improve the service. The service held monthly hip fracture meetings attended by multidisciplinary staff to review data and make improvements.

The service provided support for patients requiring additional support for their mental health. Staff showed us how they used the PIC system to refer patients with dementia to the trust’s “dignity in care” team. The trust had a psychiatric service for patients with mental health needs, such as alcohol and drug dependency. Staff discussed patients’ mental health needs at daily handover meetings and discussed whether patients should be referred to the psychiatric service.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff ensured fresh water was available for patients on the wards. The service provided a choice of hot meals and sandwiches provided for in-patients. We saw staff taking orders from patients for their meals. Special diets were catered for such as diabetic and vegetarian. We saw staff supported patients to eat and drink when required. In pre-assessment, staff provided water for patients to drink in one of the assessment rooms.

Patients attending for surgery were provided with information both verbally and through leaflets about their nutritional and hydration needs prior and post-surgery. This included instructions relating to the period they needed to be nil by mouth prior to anaesthesia, which was variable depending on the planned procedure and time of day the procedure was to be carried out. We spoke with two patients who told us the information was clear.

There was a dietetic service available for patients on special diets. Staff could also refer patients to a dietitian for advice and support after surgery.

Staff carried out a malnutrition universal screening tool (MUST) assessment pre-operatively with patients. We looked at seven patient records and saw that the MUST assessment had been carried out. Staff had completed nutrition and hydration charts where needed. Staff gave patients information on managing sickness after surgery and were asked to tell staff if they felt sick.
Pain relief

Staff provided patients with effective pain relief information, advice and medication. Staff in the pre-assessment clinic discussed pain management with patients pre-operatively. We saw in pre-assessment clinic staff provided information to patients about pain relief. The leaflets advised patients to report pain to staff and gave different ways pain relief medicines could be given.

The trust had two pain support teams, the acute pain team and the chronic pain team. Patients could refer patients to these services through the PIC system.

We spoke with six patients post-operatively who said that staff were good at looking after patient needs. The patients appeared comfortable and not in pain. The patients said staff provided pain relief if they needed it. One patient explained that staff had changed the type of pain relief medicine given to them as the original medicine did not agree with them. Another patient said that they had once waited an hour and twenty minutes for pain relief medicine but staff had apologised.

We reviewed seven patient records and saw that staff had carried out pain scores for the patients. This was to assess the level of pain the patient was in so that appropriate pain relief medicine could be given if needed.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. There were many local and national clinical audits, as outlined below.

Relative risk of readmission

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Queen Elizabeth Hospital – Elective admissions

The table below shows from May 2017 to April 2018, patients at Queen Elizabeth Hospital had a higher than expected risk of readmission for elective surgical admissions compared to the England average.

Patients in ophthalmology, general surgery and urology had higher than expected risks of readmission for elective admissions.

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.
Queen Elizabeth Hospital – Non-elective admissions

The table below shows from May 2017 to April 2018, patients at Queen Elizabeth Hospital had a higher than expected risk of readmission for non-elective surgical admissions compared to the England average.

- Patients in trauma and orthopaedics had a lower than expected risk of readmission for non-elective admissions.
- Patients in general surgery and urology had higher than expected risks of readmission for non-elective admissions.

National Hip Fracture Database

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 6.5% which was within the expected range. The 2016 figure was 5.1%.

Following the publication of the 2018 National Hip Fracture Database, the trust was highlighted as having significantly higher than expected performance. This was discussed with the surgical leadership team who said that the Chief Operating Officer for the trust managed an action plan to address these concerns.

The proportion of patients having surgery on the day of or day after admission was 69.5%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 65.1%.

The perioperative medical assessment rate was 96.5%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 87.6%.

The proportion of patients not developing pressure ulcers was 99.8%, which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 99.3%.

The length of stay was 24.2 days, which falls within the middle 50% of trusts. The 2016 figure was 24.0 days.
Bowel Cancer Audit

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2017 Bowel Cancer Audit, the number of patients undergoing a major resection with a post-operative length of stay greater than five days was not reported. The 2016 figure was 71.3%.

The risk-adjusted 90-day post-operative mortality rate was 0.0% which was within the expected range. The 2016 figure was 8.6%.

The risk-adjusted 2-year post-operative mortality rate was 18.8% which was within the expected range. The 2016 figure was 16.4%.

The risk-adjusted 30-day unplanned readmission rate was not reported. The 2016 figure was 12.9%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 63.0% which was worse than expected. The 2016 figure was 64.9%.

National Vascular Registry

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 2.2% for Abdominal Aortic Aneurysms. This was within the expected range. The 2016 figure was 2.4%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 33 days, which was worse than the audit aspirational standard of 14 days. The 2016 figure was 28 days.

The 30-day risk-adjusted mortality and stroke rate was 2.2%, which was within the expected range. The 2016 figure was 2.7%.

National Oesophago-Gastric Cancer National Audit

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2017 National Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 13.8%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2016 figure was 9.5%.
The 90-day post-operative mortality rate was 2.7%. This was within the expected range. The 2016 rate was 4.4%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.7%. This was similar to the national aggregate. The 2016 figure was 33.7%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

**National Emergency Laparotomy Audit**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the Queen Elizabeth Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 267 cases.

The site achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 128 cases.

The site achieved a red rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 159 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 108 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 267 cases.

**Patient Reported Outcome Measures**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was about the same as the England average for both indicators.

For varicose veins, scores for the Aberdeen Varicose Vein Questionnaire showed a higher proportion of patients that felt they had improved than the England average. However, for the varicose veins EQ VAS the trust had a higher proportion of patients who reported that they felt worse than the England average.

The trust did not submit any data for hip or knee replacements.

**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 monitor the effectiveness of the service.

The table below shows from April 2017 to March 2018 as 89.9% of staff within surgery at the trust received an appraisal. This is below the trust target for Queen Elizabeth Hospital of 90%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>367</td>
<td>378</td>
<td>97.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>451</td>
<td>481</td>
<td>93.8%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>66</td>
<td>73</td>
<td>90.4%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>37</td>
<td>41</td>
<td>90.2%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>945</td>
<td>1,052</td>
<td>89.8%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>389</td>
<td>454</td>
<td>85.7%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>10</td>
<td>12</td>
<td>83.3%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>295</td>
<td>358</td>
<td>82.4%</td>
</tr>
</tbody>
</table>
Queen Elizabeth Hospital

From April 2017 to March 2018, 93.4% of staff within surgery at Queen Elizabeth Hospital received an appraisal compared to a target of 90%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>32</td>
<td>32</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>193</td>
<td>201</td>
<td>96.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>363</td>
<td>383</td>
<td>94.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>523</td>
<td>560</td>
<td>93.4%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>36</td>
<td>39</td>
<td>92.3%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>100</td>
<td>120</td>
<td>83.3%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

We spoke with a matrons and ward manager on surgical wards who said that most of their staff had received annual appraisals. One ward manager told us within the next three weeks all staff would have received appraisals. We saw the appraisal plan to confirm this. Appraisals were managed at ward level but were visible centrally on the electronic dashboard. The trust’s development team could view ward appraisal figures on the system to monitor completion rates.

A sister showed us the appraisal form which included the trust values, objectives, what had gone well and not so well, and new objectives for training and development. A matron told us that they had recently completed their appraisal with their manager, Head of Nursing, and had a full plan for development.

We spoke with an occupational therapist who said their manager had checked their competency in the role using a clear structure. They said they were working with a senior occupational therapist to develop a competency checklist for future new starters. A ward manager told us there were competency checks for new starters and a competency checklist for temporary staff.

We spoke to a student nurse who had a buddy and a mentor and said this supported their learning. We also spoke with a student military nurse, a staff nurse and healthcare assistant who all said they were well supported and found the training in each specialised are to be very good. A sister said the service made opportunities for development. Health care assistants had training such as pacemaker talks, listening to murmurs and sessions to go through the resuscitation trolley which staff found interesting and beneficial.

In pre-assessment we saw staff followed guidelines for each speciality which were on the electronic system shared drive. Staff regularly checked the guidelines with consultants by email who responded with feedback with suggested improvements.

We saw that advanced nurse practitioners covered for junior doctors whilst they attended training. This meant junior doctors did not have to miss training due to clinical commitments.
**Multidisciplinary working**

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

Multidisciplinary working was evident with staff describing good collaborative working across multi professional teams. Examples included working with medical staff, allied health professionals (AHP) and dietitians. We saw this within pre-assessment and the wards where staff engaged with a wide range of professionals.

During our inspection we saw there were registrar-led multidisciplinary ward rounds with therapists in clinical areas. We looked at seven patient records where staff had completed treatment plans. For example, consultants, advanced nurse practitioners, occupational therapists, physiotherapists, dietitians and speech and language therapists documented patient progress within the patient care record. This enabled staff to take a joined-up approach to assessment of patients’ needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.

Information about patients’ hospital admission including treatment, care undertaken and prescribed medicines was sent by fax to their GP on discharge. Patients were also given a paper copy to take home. Patients were given information before being discharged from day surgery, such as taking medications and activities to avoid for 24 hours. We observed that staff included family members in discussions about rehabilitation and discharge planning. The trust had a “complex discharge team” to support staff, patients and families with patient discharge planning.

**Seven-day services**

The service ensured people received appropriate care and treatment seven days a week. The service carried out surgery over five days a week in most theatres. The service had two theatres for trauma emergency surgery and one theatre for neurological emergency surgery that ran seven days a week. For liver, cardiac and general surgery the service had an out of hours team on call in the evenings and at weekends. The service was a major centre for transplant surgery and these theatres ensured surgery could take place at any time 24 hours a day, seven days a week.

Consultants were available on call 24 hours a day and at weekends. Anaesthetists provided on call cover seven days a week.

We spoke to a physiotherapist who said that the physiotherapists provided a seven-day service for patients. Weekend cover was for three hours a day which enabled physiotherapists to carry out a physiotherapy assessment the day after surgery for patients with repair to neck of femur surgery. This was in line with National Institute for Health and Care Excellence (NICE) guidelines. Occupational therapists were not available in the evenings or at weekends. This meant that occupational therapists would have to see patients during the week and ensure any patients due for discharge were seen before the day shift finished on Friday. Therapy staff we spoke with said they managed to make this work so that patients’ discharge would not be delayed.

The trust’s pharmacy provided a seven-day service. During evenings and weekends, staff could contact the on-call pharmacist.

A cardio thoracic specialist nurse was on duty seven days a week. The service had an advanced nurse practitioner on the cardiac wards seven days a week on days and nights who could order scans and prescribe medicines.
Health promotion

Staff provided useful and relevant information to patients to promote their health. Information leaflets for all surgical procedures were available and given to patients at pre-assessment clinic. These leaflets included how to ensure patients were in the best health possible prior to admission to hospital. This included advice on diet and exercise.

In pre-assessment, staff provided information about alcohol and smoking cessation for patients. For alcohol cessation, staff gave information about the “reach out recovery service” that patients could access. For smoking cessation, staff gave patients cards with a helpline phone number. The ward manager in pre-assessment could prescribe smoking patches the same day to support patients with smoking cessation.

We looked at seven patients’ records and saw that there was a section on the PIC system where staff assessed patients for alcohol and smoking consumption. Staff could offer support to patients when the assessment highlighted a concern.

Larger patients (Bariatric) who were supported with dietetic advice from the trust’s dietitian service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. The trust combined safeguarding level two, mental capacity and deprivation of liberty safeguards (DoLS) training.

We reviewed seven sets of medical notes and found consent forms had been completed in line with the General Medical Council, Good Medical Practice guidance. Where needed, staff had completed a Mental Capacity Act assessment. We saw for one patient staff had discussed a DoLS application with a family member. Staff reviewed DoLS paperwork weekly to ensure it was still appropriate and correct.

Mental Capacity Act and Deprivation of Liberty Safeguards training

The table below shows completion of mental capacity and DoLS training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2/DoLS and mental capacity</td>
<td>545</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met this training module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in surgery at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2/DoLS and mental capacity</td>
<td>149</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We spoke with fourteen patients and four family and friends who said they were happy with the care provided. Patients told us that staff were "really helpful", "very caring" and always there for you". Patients said the food was very good and there was a good choice. One patient said of the food, they would not get better food in a restaurant.

Patients told us staff would get them whatever they needed. One patient said staff had provided them with shaving equipment promptly when they had asked for it. We observed staff providing a toothbrush and toothpaste for a patient when a family member asked for them.

We spoke to a relative who said staff had allowed their family member to have a cup of black coffee during their wait for day surgery. This was to make it easier for their family member to wait for surgery. The nurse in the surgical admissions lounge said if patients had to wait for a while in the waiting area for day surgery but were nil by mouth, they provided mouthwash for patients to rinse their mouths. They said they could call theatres and check if a patient could have sips of water before surgery if they had to wait. Staff told us the trust paid travel expenses and a meal voucher for the patient and family members if a patient’s surgery was cancelled on the day.

Friends and Family test performance

The Friends and Family Test is a national survey to measure how people feel about the service and whether they would recommend the service to their family and friends.

Queen Elizabeth Hospital

We have included data from the pre-acquisition period for Queen Elizabeth Hospital in this analysis. Because it related to the same legal entity, University Hospitals Birmingham NHS Foundation Trust, we have used this to form part of our judgement.

The Friends and Family Test response rate for surgery at the Queen Elizabeth Hospital was 22%. This response rate was just below the England average of 25%. A breakdown by ward is below (please note, only wards with at least 100 responses are shown).
The table shows that across the surgical wards, the average percentage of people who recommended the service to family and friends each month was over 90%. For some wards, there was a low result for some months over the last 12 months. However, in between April and June 2018 scores were high for all wards surveyed.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care</td>
<td>5090</td>
<td>28%</td>
<td>100%</td>
</tr>
<tr>
<td>East Block Day</td>
<td>909</td>
<td>26%</td>
<td>100%</td>
</tr>
<tr>
<td>Short Stay Unit</td>
<td>1131</td>
<td>30%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 305</td>
<td>228</td>
<td>21%</td>
<td>73%</td>
</tr>
<tr>
<td>Ward 306</td>
<td>216</td>
<td>18%</td>
<td>86%</td>
</tr>
<tr>
<td>Ward 407</td>
<td>408</td>
<td>37%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 408</td>
<td>213</td>
<td>11%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 409</td>
<td>197</td>
<td>19%</td>
<td>88%</td>
</tr>
<tr>
<td>Ward 620</td>
<td>253</td>
<td>4%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 624</td>
<td>390</td>
<td>17%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 728</td>
<td>108</td>
<td>10%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

**Emotional support**

Staff provided emotional support to patients across all areas of surgery. We observed a patient in the pre-assessment clinic. Staff had an informative approach, were caring and reassuring. We observed a nurse assess the patient. The nurse put the patient at ease by talking about the weather and checked the patient’s name and date of birth. The nurse supported the patient with taking swabs for tests and pulled the curtains to protect the patient’s dignity.

We observed a patient in theatre before their operation. Staff introduced themselves to the patient, and were calm and supportive. Staff checked the identity of the patient and complete safety checks.

On the surgical wards, staff were observed taking time to talk to patients, staff helped and reassured patients and visitors. Four family members we spoke with said they had been kept informed and were supported by staff.

Staff maintained the privacy of patients. We accompanied a patient from the day surgery ward to theatres. Staff were friendly and introduced themselves to the patient and were talking to them to reduce any anxiety about the operation. Staff used curtains to provide privacy for the patient. We saw on the surgery wards, staff pulled curtains around patients’ beds when provided personal care.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. Staff provided relevant information to patients to support them to make decisions about their treatment. At the pre-assessment clinic staff gave patients an “Information about your stay in hospital” booklet which contained information about what to bring to hospital, pain relief, and what to expect on the day of surgery. Staff also gave patients a “You and your anaesthetic” leaflet to explain what would happen at the pre-assessment clinic, preparing for an anaesthetic and what to expect on the day of surgery.

We spoke to two patients about the information staff had given them throughout the process. They told us they felt well informed by staff about their treatment and the process. We spoke with a family member who said staff had kept them well informed and were very happy with the service.
Staff supported patients with additional needs. Staff identified patients with learning disabilities when their operation was booked. A nurse supported these patients and their carers. This was to help them to understand the process. The service provided independent interpreters for patients whose first language was not English.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people. People could access the service close to their home when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

**Queen Elizabeth Hospital**

From March 2017 to February 2018 the average length of stay for surgical elective patients at Queen Elizabeth Hospital was 5.0 days, which was longer than the England average of 3.9 days.

Average lengths of stay for elective specialties:

- Average lengths of stay for elective patients in urology and general surgery were longer than the England averages.
- Average length of stay for elective patients in neurosurgery was similar to the England average.

**Elective Average Length of Stay - Queen Elizabeth Hospital**

![Elective Average Length of Stay - Queen Elizabeth Hospital](image)

*Note: Top three specialties for specific site based on count of activity.*

Over the same period, for surgical non-elective patients, the average length of stay was 6.3 days, which was longer than the England average of 4.9 days.

Average lengths of stay for non-elective specialties:

- Average lengths of stay for non-elective patients in trauma and orthopaedics and urology were
longer than the England averages.

- Average length of stay for non-elective patients in general surgery was similar to the England average.

### Non-Elective Average Length of Stay - Queen Elizabeth Hospital

![Graph showing average length of stay for different specialties.]

*Note: Top three specialties for specific site based on count of activity.*

(Source: Hospital Episode Statistics)

Senior managers and staff told us that as the hospital was a major trauma centre in England, the service treated patients with very complex surgical and post-surgical rehabilitation needs. Discharge was often complex and required community services to be available. Patients’ discharge could sometimes be delayed in order that staff could arrange appropriate rehabilitation services following discharge.

(Source: Hospital Episode Statistics)

### Meeting people’s individual needs

The service took account of patients’ individual needs. Staff helped patients with communication, advocacy and cultural support.

The pre-assessment service supported the requirement of identifying people’s individual needs. This included a comprehensive health questionnaire that nurses completed with the patients, providing the opportunity to discuss and identify specific needs. This included detailed information about allergies including latex and any medicines.

We saw a document called “This is me” that staff gave to patients with a diagnosis of dementia. Staff used a “See me: Dementia Care Bundle” which was a person-centred assessment that helped staff to support patients according to their individual needs. The trust also used a “This is me” document for patients with learning disabilities, and staff used the “See me: Learning Disabilities Care Bundle” to support patients.

We saw in the surgical assessment unit, staff used memory books to share with patients with dementia and patients with a learning disability. The books had laminated pages of old photographs of Birmingham, local newspaper articles, television and theatre pictures. The matron explained that staff could use the books to spend time with patients which helped to prevent patients becoming restless, trying to get out of bed and possibly falling. There had been no patient falls on the ward in at least the last six months.
The service provided support for patients requiring additional support for their mental health. Staff showed us how they used the PIC system to refer patients with dementia to the trust’s “dignity in care” team. The team worked with staff and families and held twice weekly meetings to discuss patient progress. The team had observed staff working on the wards to provide feedback on how staff interacted with patients. The trust had a psychiatric service for patients with mental health needs, such as alcohol and drug dependency.

We saw the service managed to keep men and women separate with all ward bays designated as male or female. Additionally, there was access to male and female toilet facilities.

**Access and flow**

Waiting times from referral to treatment for patients had recently decreased and were in line with good practice.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From August 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was above the England average, however this decreased to a similar level to the England average from April to July 2018.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to July 2018.
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>96.8%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>91.0%</td>
<td>60.4%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>90.4%</td>
<td>81.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>83.6%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat</td>
<td>75.0%</td>
<td>62.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>72.7%</td>
<td>68.5%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>60.9%</td>
<td>70.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>57.4%</td>
<td>60.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The service had systems in place to meet referral to treatment rate of 18 weeks.

We spoke with staff about theatre booking who said booking for day case surgery had a priority system. Consultants’ secretaries triaged patients by clinical need and referral to treatment waiting times. We saw that there was an electronic log to show waiting times for surgery to enable staff to book those patients who had been waiting the longest. This supported staff to meet the 18-week referral to treatment rate. For inpatient theatre bookings, consultants decided on priority and their secretaries booked patients for surgery. The group support manager, team leader and day case co-ordinator met weekly and discussed patients who were nearing the 18-week referral to treatment timescales. This was to book these patients for surgery as soon as possible.

Cancelled operations

The percentage of cancelled operations at the trust was consistently higher than the England average, however, the trust treatment rates of patients following a cancelled operation within 28 days were below the national rates.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Over the two years, this trust cancelled 3,440 surgeries. Of the 3,440 cancellations, overall, the trust had a lower rate of patients not seen within 28 days than the England average between July 2016 and June 2018.

Percentage of patients whose operation was cancelled and were not treated within 28 days
Over the two years, the percentage of cancelled operations at the trust was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

Cancelled operations as a percentage of elective admissions - University Hospitals Birmingham NHS Foundation Trust

(Source: NHS England)

Staff managed theatre admissions, responding to patient need. We observed in theatre, admissions staff reviewed a list of patients for surgery each day. A member of staff told us that where the service had previously cancelled patients, staff tried to put these patients first on the list for the day.

We saw that on the day surgery list, the service had cancelled a person’s liver surgery. Senior managers told us that they had enough liver consultants but the service lacked theatre space. Senior managers had responded to the issue by opening a third liver theatre which was due to open a month after the inspection. This would ensure the service would have to cancel less routine liver operations on the day of surgery.

Staff told us if the service cancelled a patient’s operation on the day, the service would re-book the surgery within 28 days. The patient was prioritised on the list to prevent repeated cancellation. Cancellations were escalated by staff to the theatre manager to try and find
availability in another theatre on the day. If this was not possible, the theatre manager escalated the cancellation to the director of operations to be picked up by the speciality team and re-booked within 28 days.

The group support manager and booking co-ordinator for the surgical divisions and the group support manager and booking co-ordinator for the theatre group met weekly to discuss theatre lists for the week ahead. They discussed the previous weeks to discuss any issues and cancellations. They looked at the list for the week ahead to decide if it was overbooked or under-booked to prevent cancellations on the day. Theatres used a recycled list which was sent out to the surgical specialities by email to show any theatre availability for the week ahead to prevent wasted theatre time and reduce waits for patients.

We saw an electronic log of theatre start times which showed if staff had started theatre late and the reasons. This enabled staff to monitor any issues causing theatres to start late to reduce late start times.

The service improved access and flow for patients using new initiatives. In the surgical assessment unit, we saw that the service had created a separate room for patients required intravenous antibiotics. This improved the flow of patients to avoid delays in treatment. The surgical assessment unit had also responded to patient need and opened a “hot clinic” treatment room for hand injuries where patients could receive treatment and prevent longer waits in the emergency department. Senior leaders for the surgical service told us the trust had a hand coordination team and the service employed hand coordinator nurses who were specially trained. The hand coordination nurses worked with consultants and ensured a streamlined treatment path for patients with hand injuries.

The surgical service had introduced occupational therapist led discharge for patients who required simple packages of care, lived in the Birmingham area and also had a GP also in the Birmingham area. The occupational therapists could complete the patient’s transfer of care assessment which meant there was no delay for social worker allocation. Patients benefited from reduced delays in discharge from hospital.

The service had introduced a streamlined pathway for liver surgery patients. Patients who met the criteria could go straight to the liver ward rather than critical care post-surgery. This was to reduce the length of stay for patients and improve patient outcomes.

The service had implemented a “code red” process for trauma emergencies. The hospital was a major trauma centre and had also seen a rise in complex medical emergencies such as stabbings. Consultant from all specialisms across the surgical service had agreed to be part of the code red process. Following an emergency one call was put out, theatres were alerted and a theatre was made available immediately. Consultants, anaesthetists and nursing staff immediately responded to treat patients and improve patient outcomes.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From April 2017 to March 2018 there were 188 complaints about surgery across the trust as a whole. The trust took an average of 38.8 working days to investigate and close complaints. This is over their target in their complaints policy, which states complaints should be closed within 30 working days.

Of the ten complaints still open at the time of reporting, all had been open longer than the trust’s
target of 30 working days, with the longest being open for 252 working days.

A breakdown by site is below:

- Queen Elizabeth Hospital: There were 118 complaints, the main themes were clinical treatment with 35 complaints (29.7%), patient care including nutrition/hydration with 25 complaints (21.2%), staff with 16 complaints (13.6%), admissions, discharges and transfers with 15 complaints (12.7%) and communications with 15 complaints (12.7%).

- Birmingham Heartlands Hospital: There were 39 complaints, the main themes were all aspects of clinical treatment with 25 complaints (64.1%) and admissions, discharge and transfer arrangements with six complaints (15.4%)

- Good Hope Hospital: There were 20 complaints, the main theme was all aspects of clinical treatment with 11 complaints (55.0%).

- Solihull Hospital: There were 11 complaints, the main themes were all aspects of clinical treatment with three complaints (27.3%), appointments, delay/cancellation (in-patient) with three complaints (27.3%) and communication/information to patients (written and oral) with two complaints (18.2%).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We spoke with two matrons who said that they investigated any complaints relating to patients on their wards. Matrons attended ward risk team meetings held at least once a month where incidents and complaints were discussed. The matrons were aware of duty of candour (keeping people’s families informed during investigations) and understood how to put this into practice. The matrons identified learning and actions from complaints and shared these with staff. Ward managers said they would talk to the staff involved about complaints. The deputy head of nursing held monthly “preventing harm” meetings with matrons to discuss learning from incidents and complaints across wards.

We spoke with a matron on a surgical ward who spoke daily with family members of a patient. Where the family raised any issues, the matron acted quickly to address these and kept the family informed.

There had been previous concerns raised about bullying within theatres and critical care. We spoke with surgical senior managers about this. In response to concerns raised by staff within the liver speciality and cardiac theatres, the service introduced real time governance meetings held every two weeks and attended by the clinical service lead, anaesthetist, divisional and theatre leads and staff from the surgical wards. During meetings staff reviewed any positives and negatives at that time. A senior manager told us there were now more positives than negatives in the meeting. Senior managers encouraged staff to report any bullying through the incident reporting system and took a zero-tolerance approach to bullying.

Previous concerns had been raised about cardiac surgery and cardiac intensive care relating to staffing and patient safety. We carried out a short notice focussed inspection in December 2015. We issued a Section 31 Notice of decision to urgently impose conditions on cardiac surgery at Queen Elizabeth Hospital against the registered provider. The trust had to complete an external review of cardiac surgery at the hospital by February 2016. The trust also had to provide us with weekly mortality and patient safety data. During this inspection we spoke with surgical senior leaders about actions since our previous focussed inspection. Senior leaders told us that all required actions had been completed. The service provided us with the required data for 12 months and an external review including involvement of the Royal College of Surgeons. Senior leaders said staff still held daily meetings to monitor the cardiac service improvements.
Compliments

From April 2017 to March 2018 there were 627 compliments within medicine.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>490</td>
<td>78.1%</td>
</tr>
<tr>
<td>Nuffield House</td>
<td>119</td>
<td>19.0%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>12</td>
<td>1.9%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>627</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

**Is the service well-led?**

**Leadership**

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. Leadership for surgery was through clinical leads, head of nursing, operational and business management. Supported by specialism heads of service, senior matrons, matrons and ward sisters. The range of experience within the senior team enabled effective leadership of the surgical service.

Staff told us they felt local managers were visible, approachable, supportive and they received appropriate support to allow them to complete their jobs effectively.

Staff we spoke with were positive about the two divisions for surgery. Surgery fell into the trust’s Division B and Division D. Each division consisted of several surgical specialisms.

**Vision and strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action. The trust vision was outlined in the trust’s annual report and accounts 2017/2018. The trust vision was to “deliver the best in care” to their patients under the core purposes of clinical quality, patient experience, workforce and research and innovation. The trust’s key values were honesty, innovation, respect and responsibility.

During our inspection, we met and spoke with staff in pre-assessment, on the surgical wards and operating theatres who demonstrated the trust’s values by working together to provide a seamless service for patients.

We found manager across the service to be highly motivated to the trust’s core purposes. Senior leaders worked well across specialities to make patient focussed innovative improvements to surgery to improve patient outcomes.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff and was centred on the needs and experience of patients and their families. Managers told us this positive culture created a sense of common purpose, for staff, based on shared values. Staff told us they enjoyed working for the surgery service and felt valued in their work. They said there was a family
spirit and staff worked well together. A member of staff told us they had worked in the service for many years and were happy working there. Staff told us they felt comfortable with raising concerns with managers.

The trust completed the workforce race equality standard (WRES) indicators report in July 2018, which, indicated there had been a considerable amount of work to promote racial equality. This included the new “Queen Elizabeth Network” which was a black and minority ethnic staff network. The network contributed to the WRES work and input into trust policies and procedures.

**Governance**

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust used a systematic approach to continually improve the quality of the service.

Ward matrons explained they produced figures to present at the meetings such as staffing, training and incidents. They said the structure worked well for them and enabled a more focused approach.

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There were corporate electronic risk registers in place for recording and managing risks. The risk registers included a description of each risk, initial risk rating and current risk rating, the owner and actions taken.

At ward level, matrons told us they attended ward based risk team meetings held at least once a month where risks were discussed. The ward manager decided the level of risk for each incident and escalated more serious incidents to the matron.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Actions around access and flow data

The trust collected, analysed, managed and used information well to support all its activities using secure systems with security safeguards. The service kept patient records secure in locked cabinets and locked computer stations. Staff only included care records in patient end of bed paper records and did not include medical records.

Service performance measures were reported and monitored. The matrons and ward managers had access to a quality and safety figures, which displayed performance measures. The information was displayed on the electronic dashboard in the PIC system. This meant staff could see at a glance how well wards were performing.

The trust published an annual report and accounts 2017/2018 on the trust’s public website. This covered challenges, risks, performance and accounts for the year.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
Surgical wards and operating theatres held team meetings, and staff took notes so they could be shared with staff who could not attend. These provided relevant updates about the division and the wider trust. A staff huddle took place at the beginning of each day for sharing and learning purposes. Staff spoke positively of being involved in decisions and new ways of working.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The service had put many innovative projects in place to improve the service for patients. One example was the service had introduced a “hot clinic” in the surgical assessment unit to treat patients with hand injuries. Staff on the surgical assessment unit ward staff had also created a room for patients requiring intravenous antibiotics so that their treatment would not be delayed and they did not have to sit in the waiting room.

The service had started single nurse sign out for oral morphine for pain relief across the service. This had reduced delays in staff administering pain relief.

The service was a lead in maxillofacial surgery. The service had a maxillofacial laboratory in theatres and a maxillofacial ward. The service also offered surgery for ear, nose and throat, trauma and plastic surgery. The service used 3D printers in the prosthetics laboratory to model parts of the face and body for patients. Clinical nurse specialists and nurse educators trained nurses to manage patients with complex requirement, such as tracheostomy patients. The service employed a biomedical engineer to develop the products for the service.

The service had many leading developments in the ear, nose and throat speciality to improve patient outcomes. These included the first ever local anaesthetic pituitary operation and a new navigation system with a 3D screen.
Outpatients

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

This appendix focuses solely on the provision of outpatient services from Queen Elizabeth Hospital.

The outpatient department is located within the main hospital entrance and comprises four designated areas. There are 268 procedure rooms, including treatment rooms. The following specialities provide clinics across the four areas:

Area 1: diabetes, endocrine, genitourinary medicine, podiatry medicine, pain, neurosciences, neurophysiology, ophthalmology care, rheumatology, orthotics

Area 2: renal, urology, liver, ENT, maxillofacial, gastrointestinal physiology, upper gastrointestinal / colorectal / gastroenterology, pre-operative assessment

Area 3: general medicine / elderly care, cardiology, cardiac surgery, respiratory, vascular and transient ischemic attack.

Area 4: dermatology, burns and plastics, hands and trauma and orthopaedics

In addition to recurrent outpatient clinics, some specialities will reflect the flow of emergency/hot clinics to support early discharges either in-patient or accident and emergency and clinical decision unit assessment areas. The neuro-ophthalmology service is the biggest of its kind in Europe. The specialties which saw the highest number of outpatients were cardiology, clinical and medical haematology, clinical oncology, dermatology, hepatology, nephrology, ophthalmology and trauma and orthopaedics.

Number of appointments - Queen Elizabeth Hospital outpatients

In 2017/18 University Hospitals Birmingham was the fifteenth largest provider of outpatient services in England and Wales.

From June 2017 to May 2018 the trust had 1,079,578 outpatient appointments and 97% of these were at Queen Elizabeth Hospital.

In common with many outpatient services, University Hospitals Birmingham (UHB) was experiencing an increase in demand for many specialties. In 2017/18, there were 3% more outpatient and oncology (cancer outpatient) attendances than in 2016/17. This was an increase of 26618 attendances.
This increase in demand over the last year particularly affected dermatology, surgical specialties, oncology and ‘other’ specialties.

**Type of appointments**

Outpatient attendance at Queen Elizabeth Hospital June 2017 to May 2018 showed that 16.6% were first or new appointments and that non-attendances were approximately 6% of appointments:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>% of attends</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Attended first appointment</td>
<td>16.6%</td>
</tr>
<tr>
<td>2</td>
<td>Attended subsequent appointment</td>
<td>76.3%</td>
</tr>
<tr>
<td>4</td>
<td>Did not attend first appointment</td>
<td>1.8%</td>
</tr>
<tr>
<td>5</td>
<td>Did not attend subsequent appointment</td>
<td>4.1%</td>
</tr>
<tr>
<td>13</td>
<td>Not known</td>
<td>0.0%</td>
</tr>
<tr>
<td>21</td>
<td>Attended first tele consultation (from 2008-09)</td>
<td>0.0%</td>
</tr>
<tr>
<td>22</td>
<td>Attended subsequent tele consultation (from 2008-09)</td>
<td>1.1%</td>
</tr>
<tr>
<td>24</td>
<td>Did not attend first tele consultation (from 2008-09)</td>
<td>0.0%</td>
</tr>
<tr>
<td>25</td>
<td>Did not attend subsequent tele consultation (from 2008-09)</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training completion rates

Queen Elizabeth Hospital

The service provided mandatory training in key skills to all staff but completion rates were variable. Data for medical staff was reported within individual directorates rather than through the outpatient service.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in outpatients at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident planning</td>
<td>101</td>
</tr>
<tr>
<td>Information governance</td>
<td>93</td>
</tr>
<tr>
<td>Infection control</td>
<td>93</td>
</tr>
<tr>
<td>Fire training</td>
<td>91</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>75</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>5</td>
</tr>
<tr>
<td>Manual handling</td>
<td>56</td>
</tr>
</tbody>
</table>

In outpatients, the hospital had an overall training compliance rate of 89.4% for qualified nursing staff, just short of the trust target of 90%. The trust’s training targets were met for three of the seven mandatory training modules for which qualified nursing staff were eligible. The manual handling module had the lowest completion rate, at 71.8%.

The service had a rolling programme of training and we saw that the shortfall on conflict resolution training was mostly in Area 4 (dermatology, burns and plastics, hands and trauma and orthopaedics). Area 3 (general medicine / elderly care, cardiology, cardiac surgery, respiratory, vascular and transient ischemic attack) was not up to date with manual handing training. Senior nurses attributed this to sickness and maternity leave.

Medical staff working within outpatients reported through their individual specialties and not to the outpatient service. However, training data was provided for medical staff within the oncology clinic. A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in outpatients at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident planning</td>
<td>3</td>
</tr>
<tr>
<td>Information governance</td>
<td>1</td>
</tr>
</tbody>
</table>
In outpatients, the hospital had an overall training compliance rate of 50.0% for the oncology medical staff who reported directly to outpatients. The trust’s training targets was met for one of the four mandatory training modules for which medical staff were eligible. However, it should be noted that this relates to a very small number of staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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. We saw evidence that all Safeguarding level 2 training was up to date in September 2018.

Safeguarding training completion rates

Queen Elizabeth Hospital

Nursing staff were up to date with their safeguarding training and that there was a safeguarding champion for outpatients.

There were only three members of medical staff who reported within the outpatient service and they had completed their safeguarding training. Most consultants and doctors working in clinics reported within the specialty and divisional structure and not within the outpatient service specifically. Levels of three-year compliance with safeguarding training for these clinicians were over 90%.

The services acted to ensure that children were safeguarded. The trust recognised that many children accompanied their parents to outpatients or were seen in outpatient clinics. In addition to the Level 2 training which all outpatients staff received annually, the trust safeguarding team and the outpatient clinical education were training outpatient staff to Level 3 standard. They aimed to train 95% of outpatient staff to this standard by 2019, which exceeded the requirements of the Royal College of Paediatrics and Child Health intercollegiate guidance for child safeguarding.

Although there was no electronic flagging system, consultants were trained to identify and help vulnerable people, for example those at risk of abuse. There were arrangements to safeguarding women or children at risk of Female Genital Mutilation (FGM).

Consultants in clinics who had concerns about outpatients mental or social needs referred them to social work or mental health professionals. Some clinics had social workers attached, for example for patients with diabetes, and liver, neurology conditions, HIV and pain. There was also a tissue viability team and falls champions, and a specialist falls clinic. There were also champions for mental health, dementia and dignity. This provided outpatients with additional support to ensure they were safe.

Cleanliness, infection control and hygiene

Overall, we found the outpatient areas to be visibly clean. Standards of hygiene were good and staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste. We saw cleaning schedules which were up to date in public areas and in consulting rooms. We observed nurses and clinicians who were bare below the elbow and who washed their hands at before, during and after an outpatient consultation.
Staff made appropriate arrangement for outpatients with contagious diseases. Clinics were prepared the day before and if staff knew that a patient coming in needed to be isolated, they could identify a separate room and arrange to take the patient straight there.

Staff tried to minimise the risk from patients with chest infections. GP-referred patients needing a chest x-ray shared the same waiting area as fracture clinic outpatients. The imaging service asked GPs to refer chest x-ray patients to attend between 8 and 10 am. This was a quieter time, and would reduce the potential risk to fracture clinic outpatients. However, some patients were still referred in the afternoon, so the issue was not completely resolved.

**Environment and equipment**

The outpatient environment and equipment were fit for purpose. Since our last inspection the hospital had re-located some clinics to other facilities, such as the clinics for rare diseases. This provided more clinic space at Queen Elizabeth hospital.

The outpatient environment at Queen Elizabeth hospital was modern but not all waiting areas were well lit, we noticed this particularly in ophthalmology. The diabetes service was in an older environment in the Nuffield building, but this was made comfortable for patients. There were vending machines where outpatients could buy snacks. The cancer centre was in the Heritage building with a bright welcoming atrium and a snack bar run by volunteers.

Most clinics appeared well equipped, however, staff told us about equipment shortages particularly in rheumatology, for example weighing scales and urine analysis machines. This contributed towards a backlog of patients.

The hospital reviewed the outpatient environment regularly. We saw evidence that the fracture clinic audited its environment and identified that new couches and bins were needed.

Resuscitation equipment was readily available. We checked four resuscitation trolleys in outpatient areas 1-4. Most resuscitation trolleys we checked were fully equipped and clean.

However, this was not consistent. We noted that in Area 3 – Reception 2 there was an emergency drug box stored on floor next to the trolley. On the trolley there was an oxygen mask with open packaging. The trolley had not been checked daily, with seven days missing from August, five days from September and two days from October 2018. The staff member we accompanied checked the trolley from memory and did not use a standardised list of required trolley contents.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. They explained very clearly to us the procedures for escalation in situations of increased patient risk. They would ensure that they were seen by the consultant as soon as possible if they thought an outpatient was unwell.

The escalation process was supported by published guidance for nurses in outpatients, the Deteriorating Patient Guide 2016, which we viewed on the intranet. This included the procedure to admit a deteriorating patient to the ward. Senior nurses told us this could be improved by further tailoring it to the needs of outpatients.

Staff told us that outpatients had no specific tool for sepsis. If patient monitoring showed a risk or if they suspected the signs of sepsis, they would ask the consultant to see the patient urgently so that they could get the patient admitted. Registrars would attend direct from the ward if needed.

The trust had processes to minimise risk to follow up patients where there were backlogs. For example, in ophthalmology, follow up patients were seen in order of clinical risk relative to their wait time. When we inspected, in ophthalmology 751 new patients and 3589 follow up patients were waiting to be seen by consultants. The service had an ophthalmology follow up tracker which
was reviewed weekly at the ophthalmology waiting list meeting, and clinic coordinators requested additional capacity where needed. Issues were escalated to a range of meetings including the ophthalmology clinical governance meeting and the operational delivery group. This meant that the service and the trust monitored and acted on risk to individual patients.

Staff had access to mental health liaison services via the emergency department but they explained that this took ‘a bit of time’. Two mental health nurses were recruited to support trust staff with patient mental health issues. Usually staff were aware of an outpatient’s mental health needs before their attendance and ensured that they were seen at the start or end of a clinic to avoid any waiting time.

Clinics worked well with other professionals to meet individual outpatient’s physical and mental needs. Consultations included an assessment of vulnerability and there was an escalation process and risk assessment process to refer to on the internet if clinicians had a concern about this. Some clinics had social workers attached, for example for patients with diabetes, and liver, neurology conditions, HIV and pain. There was also a tissue viability team and falls champions, and a specialist falls clinic. The service had champions for mental health, dementia and dignity, and four link nurses for dementia care, one for each outpatients’ area.

Outpatients staff had response arrangements if a patient collapsed in the outpatients’ area. Nurses explained that the senior nurse who was bleep holder would receive an alert if this happened. Nearby nurses not engaged in care would assist the person who had collapsed.

Nurses stayed with outpatients until it was safe for them to leave the hospital. For example, a nurse stayed with an ophthalmology outpatient until 9 pm to ensure that the patient transport had arrived and that the outpatient could safely leave the hospital.

**Nurse staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Staffing requirements were based around the needs of individual clinics and staffing levels could be flexed up and down. Several clinics had clinical nurse specialists who saw their own patients. If there were any shortages, staff from another outpatient speciality would help. Leaders were trying to encourage more flexibility through giving nurses and health care assistants experience in a range of specialties.

The trust reported their staffing numbers for qualified nursing staff in outpatients below for the periods March 2018 and June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
<td>Fill Rate</td>
<td>Actual staff – WTE in month</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>142.6</td>
<td>200.0</td>
<td>71.3%</td>
<td>146.9</td>
</tr>
</tbody>
</table>

**Vacancy rates**

Staff vacancies at Queen Elizabeth Hospital were relatively high. From April 2017 to March 2018 the vacancy rate in outpatients was 18.6% Trust wide, however the vacancy rate was 11.5% for
nursing staff in outpatients over the same period. Queen Elizabeth Hospital did not have a target vacancy rate. Outpatients leaders told us they were constantly recruiting and looking at better ways to retain nursing staff, which included skills development and job enrichment.

Certain vacancies were difficult to recruit to, such as ophthalmology nurses; in this case the service trained its own nurses to do the job. There was an induction process for all new nurses and healthcare assistants.

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 7.0% for qualified nursing staff at Queen Elizabeth Hospital in outpatients. The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

This was not an excessive turnover rate compared with other large trusts. Senior staff told us about nurses and health care assistants who had been with the trust for many years and others who had returned after officially retiring. They explained that many of the younger staff, particularly health care assistants, chose to move on after gaining experience at the hospital.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 5.8% for qualified nursing staff at Queen Elizabeth Hospital in outpatients; this is higher than the trust target rate of 3.6%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Leaders in the outpatient service recognised this was an issue and had implemented the corporate sickness absence procedure. Much of the outpatient nursing workforce was nearing retirement, however, and there was more long-term sickness than average.

**Bank and agency staff usage**

The trust reported there were 4,728 qualified nursing shifts filled by bank staff, none by agency staff and 319 shifts left unfilled in outpatients at Queen Elizabeth Hospital.

Outpatient services only used trust bank staff, who were known to them. This was to cover for all levels of staff. They never used external agencies because they preferred to be sure of their level of competency.

**Medical staffing**

The trust did not provide any medical staffing data for outpatients as medical staff do not fall under the outpatients core service. They reported within their respective specialty.

Medical staffing was frequently reviewed because many specialties were in a situation of increasing demand.

Leaders recognised that in some specialties medical staffing needed to be increased, for example, neurologists to meet epilepsy need, and to reach referral to treatment targets sustainably.

**Records**

Staff kept detailed records of outpatients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
Medical records were electronic except for ophthalmology clinic records. Electronic records were treated securely and manual records were tidied away.

The Trust had developed MyHealth, an electronic patient record system. This had a clinical and patient portal and patients with chronic conditions were encouraged to register with MyHealth to see their own electronic medical records. Cardiac patients were also encouraged to keep a record of their electrocardiogram (ECG) on their mobile phones in case of emergencies.

Not all information for consultations was delivered in a timely way. We saw a cardiology consultation where the patient’s scan was not electronically available. The consultation was not cancelled and the patient had a helpful consultation.

**Medicines**

Outpatient specialities did not consistently ensure the safe and proper use of medicines. We found stock beyond or nearing expiry in some areas: magnesium sulphate injections expired in July 2018 and salbutamol inhalers with an expiry date of October 2018 in Area 1.

The endocrine fridge had too much stock and some of it was dated February 2018. Temperatures outside of the agreed parameters of two to eight degrees centigrade were recorded on fridge checklists, one temperature recorded was 20 degrees centigrade. This did not ensure the safety of the drugs.

There were safe storage arrangements for controlled drugs and chemotherapy given in outpatients. Cancer services also had antibiotics to respond to sepsis in outpatients quickly. This could be done under patient group directions (PGD) in the cancer centre. This meant that specified nurses could supply or administer these medicines directly to the patient without the need for a prescription. They also had other treatments in stock to avoid cancer patients having to go to the pharmacy.

**Incidents**

Staff we spoke with knew how to report an incident or problem. The electronic incident reporting system had the facility to feed back to the person who had originally logged the incident. Each nursing lead (Sister) got their own record of incidents recorded for their area, and senior nursing leads monitored incident trends. Clinic delays of over 60 minutes were recorded on the patient appointment system and this was recorded as an incident and reported to the group manager.

Senior nurses gave us an example of learning from incidents occurred after laser treatment was applied to the wrong eye by mistake. This was discussed at specialty and divisional management meetings and resulted in applying the World Health Organisation (WHO) surgery safety checklist in outpatient clinics which had day surgery such as dermatology or ophthalmology.

Arrangements for reviewing incidents and sharing learning were effective. For example, cancer services had a monthly harm review meeting where they reviewed cases and recognised themes. They sent an incident report to commissioners if the harm had occurred at another provider so that the issue was followed up. They also had a 104-day harm review meeting to review the care of patients who transferred to Queen Elizabeth from other hospitals.

The service took action to notify patients of an incident and offer an apology in line with the Duty of Candour. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Nurses and clinicians told us about examples and we saw cases recorded in clinical governance meetings which showed that the service was open and honest with individual outpatients about its mistakes and unexpected events. Leaders told us they reminded staff regularly about this duty.
Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From August 2017 to July 2018, the trust reported no incidents classified as never events for outpatients.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England occurring between August 2017 and July 2018.

Between August 2017 and July 2018, the hospital reported two serious incidents (SIs) in outpatients, an optometry information governance incident in August 2017 and a delayed diagnosis of pancreatic cancer in a patient who had been referred by their GP in October 2017.

The trust investigated and learnt from the optometry information governance incident. It responded by suspending the service and letting patients know there were staffing issues. The service re-recruited optometrists and ensured appropriate clinical supervision was in place. The ophthalmology specialty planned to present the findings and learning at the next Clinical Governance meeting.

The investigation of the pancreatic cancer delayed diagnosis incident was delayed, due to the investigator’s long-term sickness, but was due to be finalised in November 2018.

Safety Thermometer

There was no safety thermometer dashboard in place in outpatients to display quality and performance information for the public. However, outpatient steering group minutes showed that a task and finish group were identifying the information needed for a dashboard, so development work was in progress.

Is the service effective?

Evidence-based care and treatment

Cancer services had robust internal processes to promote evidence based care and treatment. Cancer services contributed to national audits across a range of specialties. Each consultant’s treatment of tumour sites was peer reviewed, giving patients a second opinion systematically. We saw evidence of specialties services learning from audits and comparisons in outpatients, for example, cardiology participated in the NHS England Congenital Patient Review.

Cancer services gave us an example of how they led good practice. A lead consultant adjusted the pancreatic cancer pathway so that the patient goes straight to surgery without having a stent. After this was trialled and reported it was adopted nationally.

Specialties benchmarked themselves against other hospitals to improve effectiveness, for example, trusts in Sheffield and Liverpool. They were also starting to compare practices with the newly acquired Heart of England Foundation Trust (HGS) Heartlands, Good Hope and Solihull hospitals.

Care in specialty clinics followed national guidance. Specialties also audited how well they did this. For example, for glaucoma care and cataract cancellation, which enabled comparison with other
hospitals. Clinicians presented their audits at a six-monthly meeting to share findings and improvements. We observed clinicians and nurses in cardiology, ENT and neurology who were following national guidance in their treatment of outpatients.

Outpatient areas had monthly audits in the same way as the wards. Each specialty ran their own audits and the programme had to be signed off at trust level.

The hospital did not have an annual clinical audit programme for outpatients but this was under discussion at Outpatients Steering Group.

**Nutrition and hydration**

There were arrangements for some patients to fetch food and drink from elsewhere if they were waiting for a long time. ENT and colorectal outpatients could take pagers to enable them to leave the area and still be alerted if it was time for their appointment. Staff told us they were more often used by ENT patients because a coffee retailer was located next door to the colorectal clinic so patients did not necessarily need a pager because they did not need to go far for refreshment.

The hospital was carrying out an audit on the use of pagers at the time of our inspection.

There were snack vending machines around the outpatients’ areas, and a snack bar in the cancer centre.

**Pain relief**

Clinics were able to prescribe one-off pain relief to outpatients. The outpatient service was starting to monitor levels of outpatient pain within clinics. In August 2018 it conducted a pain audit in its fracture clinic. This showed that only 33% of outpatients experiencing pain were given analgesia. The audit resulted in an action plan to raise awareness amongst staff that outpatients in all clinics might be in pain and that the pharmacy could dispense single doses of analgesia if doctors requested. Following the audit, senior leaders decided that pain scores would be included where patient observations (weight height, blood pressure) were taken and documented.

The service also printed informative patient leaflets and posters on pain and pain management and planned to add the information to patient plasma screens in October 2018.

**Patient outcomes**

The ratio of follow up to new appointments was reviewed appropriately. Although the follow-up to new rate for Queen Elizabeth Hospital was higher than the England average, the service reviewed the use of follow up appointments in some of its clinics to monitor whether consultants time was best utilised. Since our last inspection, specialties had changed their approach to follow up appointments and clinicians did not ask outpatients to book an appointment if they could self care or if they were monitored by another healthcare professional. They also reviewed outpatients who had been referred from tertiary centres to see if they could be returned to their home hospital.

We saw examples of clinical nurse specialists offering follow-up appointments in clinics while doctors saw new patients. Clinical nurse specials offered follow up appointments in some neurology disciplines where the consultant would see the outpatient on their first appointment.

**Competent staff**

Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. Between April 2017 and March 2018, the outpatient services at Queen Elizabeth hospital reported an overall appraisal completion rate of 82.7%, which was less than the trust target of 90%.
The hospital showed us updated information which suggested that in September 2018 all nursing staff had received an appraisal except one staff member who was on maternity leave. Senior nurses (band 6 and 7s) within each speciality had the responsibility of ensuring that staff were up to date with their training.

The service was strengthening levels of competence. Outpatient services had a clinical educator who was responsible for all nurse education. Staff had their own competency booklet. Clinics had core staff who were trained to a level of competency to meet the specialism of the individual clinic, for example in dealing with ENT scopes or removal of sutures (stitches), and each clinic had its own protocols.

Leaders recognised that it was advantageous to cross-train staff so that they were familiar with more than one specialty, for job enrichment and retention reasons and so that there was more flexibility in the workforce.

Health care assistants were encouraged to gain skills so that they could take on more responsibility. Leaders allocated an experienced nurse as a mentor to each healthcare assistant.

**Multidisciplinary working**

Regardless of their team or medical discipline, all the necessary staff were involved in patient care. Cancer services had reorganised to provide 24 different multidisciplinary team meetings (MDTs) to determine care plans and review cases for different groups of cancer outpatients. The skin cancer team was the largest of its kind in the UK. The urology MDT, for example, included urologist, oncologists, uro-radiologists, histopathologist, clinical nurse specialists and a pathway coordinator. This gave the service more stability and increased opportunity for patient focus, cooperative working and carrying out audits and research. The services also reviewed patient pathways to integrate them with other services to streamline the patient’s journey.

Services aimed to deliver a one stop shop approach for outpatients and we saw several examples of coordinated and patient centred approaches. In hepatology, the lead nurse ran a liver fibroscan clinic in advance of consultants’ appointments so that the results were available for clinic, during the same patient visit to the hospital. Fracture clinic linked with physiotherapy so that consultants could refer low risk patients directly to physiotherapy in the same visit. In cardiology, we saw a staff member coordinating a patient’s follow up consultation so that the echocardiogram was done on the same day, to avoid repeat visits. We saw an ENT consultant working with a speech therapist to deliver a more holistic service to the patient.

Clinical nurse specialists (CNS) offered a variety of clinics across specialities. In cardiology, there were nurse-led heart failure clinics and for adult congenital heart disease outpatients. Cancer services had 79 CNS across a range of specialties who offered clinics and practical support to patients. For example, in urology there was a total of 9 CNS (5 benign 4 oncology), some of whom were nurse prescribers, who ran clinics such as for catheter changes and bladder installation.

There were established links with mental health services, learning disability, autism and dementia services. There were social workers attached to some clinics. The service had champions for mental health, dementia and dignity and four link nurses for dementia care – one per outpatients’ area.

However, in fracture clinic there was a missed opportunity in that a geriatrician did not attend the clinic to give older people general advice. Many of the patients attending fracture clinic were older patients who could have benefitted. There was a falls nurse, however.
Sometimes a mismatch of capacity across hospital services inhibited flow. Clinicians and staff in cardiology told us their main frustration was the lack of ITU beds, and we observed queues in fracture clinic waiting for x-ray, which caused appointment delays.

**Seven-day services**

Outpatients services were not yet available seven days a week on a regular basis. Various specialities and cancers services offered Sunday and evening clinics, which met the needs of outpatients of working age.

**Health Promotion**

Health care assistants promoted healthy living at pre-assessment in outpatients. They informed the patient about services within their local area, for example for smoking cessation, while they recorded the patient’s height and weight.

The service invited organisations to staff a desk in their reception area to promote aspects of health. During our visit we saw representatives from the local mental health trust distributing leaflets in reception about a range of mental health conditions, and there were plans to invite a carers organisation to the outpatient area to promote their activities.

Cancer services worked with GPs to increase awareness and deliver training days for GPs but also gave them specific information, for example about prostate cancer. On a more informal basis, the upper gastro-intestinal team had a curry night with GPs.

However, vending machines and the shop within the foyer area of the hospital sold mainly sandwiches and snacks high in sugar and chocolate bars. This did not promote good health.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Mental Capacity Act and Deprivation of Liberty training completion

Consent processes were used appropriately in outpatient areas. We saw clinicians and nurses informing outpatients about risks related to procedures and medication and asking for their consent before examination. Consent was audited trust-wide.

The trust combined safeguarding level 2, mental capacity and deprivation of liberty (DOLs) training. This training was up to date in September 2018.

**Is the service caring?**

**Compassionate care**

We observed clinical and non-clinical staff speaking to patients and relatives in a respectful and considerate way. Outpatients could speak to receptionists without being overheard and clinicians we saw did not rush consultations with patients.

Staff responded in a kind and compassionate way to patients. In rheumatology an outpatient informed us that they had arrived early and that the consultant had seen them ahead of their appointment rather than keep them waiting. After the appointment, a healthcare assistant then took the patient, who was in a wheelchair, across the plaza in front of the hospital to the railway station so that they arrived on the right platform to catch the train.

Consultants we observed engaged with patients in a reassuring and approachable way. They ensured that outpatients understood the plan for their care and left time for questions at the end of the consultation.
Staff displayed understanding of outpatients living with dementia or learning disability. We saw nurses and clinical staff prioritising their treatments.

A chaperone was automatically provided to female patients because a nurse routinely attended the consultation with the consultant and patient. A male nurse in fracture clinic described how he acted as a chaperone to male patients. Although chaperones were provided, chaperoning was not formally documented in patient records.

However, the queuing system for X-ray imaging before fracture clinic did not demonstrate compassion for patients. We observed a queue of 20 patients, many of whom were frail, elderly or injured, waiting to check in at around 13:30 and only two receptionists at the desk. This obliged the patients to stand up while queuing, for up to 20 minutes. This bottleneck was purely due to lack of staff at the desk because there were four X-ray machines available for outpatients. Staff explained that the hospital had a task and finish group working on how to solve the problem but this had not alleviated the situation for patients so far.

Patient privacy was not consistently maintained. We observed in Area 1 a small room used for drug storage where a nurse was taking a blood sample from an outpatient. The process was interrupted twice by staff members entering the room to remove drugs.

**Emotional support**

We observed clinicians discussing treatment options with outpatients and encouraging them to make decisions about their own care plan.

Clinical nurse specialists (CNS) offered ongoing emotional support to patients with life changing conditions, for example, ensuring that Hepatitis C patients could contact them by phone to discuss their diagnosis.

The service offered support to patients who were alcohol dependent. A specialist addiction nurse attended liver CNS clinic and the adult learning disabilities service ran specialist clinics, notably in hepatology (liver). The liver specialty also had access to the Reach Out Recovery Alcohol Referral team.

The ophthalmology specialty followed good practice by having an Eye Clinic Liaison Officer (ECLO) known otherwise as a qualified sight loss advisor. The post was funded by Birmingham Vision. Sight loss advisers use their expertise to give emotional support to the patient, identify their individual needs and refer them onto vital support services. Clinicians or senior nurses could refer outpatients to the ECLO who would contact social services, or relevant charities such as Guide Dogs for the Blind. This helped outpatients adjust to sight loss.

Cancer services were co-located with the Patrick Centre for patient advice and the Macmillan benefits advice service. There were clinical nurse specialists attached to clinics who would talk through cancer diagnoses afterwards with patients. They could refer individual patients to an oncology psychologist for further specialist emotional support.

**Understanding and involvement of patients and those close to them**

Cancer clinic nurses ensured that patients received appropriate information about their illness. In specialty clinics we visited there was a wide variety of informative leaflets available.

We observed nurses and clinicians involving carers and family members in important decisions about their treatment.
Outpatients were actively involved in their care. For example, the cardiology specialty clinicians encouraged patients to keep their electrocardiogram (ECG) on their mobile phones in case of emergencies.

Outpatients were clear on what would happen next and that they would know who to contact if they were worried about their condition or treatment after they left hospital. They told us they had received information about this. However, the hospital’s own feedback showed this was not always the case.

We asked ten outpatients waiting in a variety of specialty waiting areas and two patients waiting in the cancer centre for their views on care. Most were happy with their care but the less positive comments related to car parking, finding their way to the correct waiting area, waiting time or lack of information about care and treatment of fractures specifically.

Is the service responsive?

Service delivery to meet the needs of local people

The service was responding to the needs of the Birmingham population. Demand for outpatient and cancer services had increased by 3% between 2016/17 and 2017/18, which equated to 26618 more attendances. Senior managers and clinicians told us that where possible they were developing services with HGS, primary care or commissioners at community level, such as for medical retina work, community based glaucoma provision and cataract follow-up. In cancer services there were similar plans to take services out to the community, in particular for chemotherapy patients. Other plans included expanding virtual clinics and using artificial intelligence. (AI)

Clinics responded to need in all sections of the local population. For example, the service offered specific lupus clinics. Lupus is an autoimmune condition experienced mainly by women but more common in those of Asian and Afro-Caribbean heritage than white women.

Outpatient services responded positively to unmet need. We saw evidence that cancer MDTs and outpatient’s specialties identified new services such as for outpatients with rare cancers or neurological conditions. They developed plans to meet these needs. Cancer services responded to the increase in demand for all cancer services including radiotherapy. They offered some evening clinics. Plans were in place to deliver services in the community or at home. To respond to increasing demand, cardiology planned heart transplant and obstetric cardiology clinics.

During our last inspection in 2015, some areas in the outpatient service were overcrowded and some rooms were too small to include junior doctors in the consultation. We also found that consultation time for outpatients with complex conditions needed to be increased. During our 2018 inspection, we found that the outpatient rooms and areas used at Queen Elizabeth Hospital (QE) were still the same. However, since then the service had alleviated the pressure on rooms by locating more complex outpatient clinics or research clinics in other buildings such as the Institute of Translational Medicine or in the Heritage facility. The haematology service was expanded and relocated away from the main outpatient areas. This released capacity in the QE outpatient areas, so that more clinics could be offered, and outpatients with complex conditions could have longer consultations.

A wide variety of specialty and medical condition related leaflets for outpatients was available on the trust’s website; these were for information rather than support and did not include contact details of staff within specialties.

The hospital had an in-house pharmacy which enabled outpatients to collect their medication when they left the clinic. There were queues but queuing time was not long, and patients found the pharmacy helpful.
The trust acknowledged that it could improve its did not attend (DNA) rate which was approximately six percent for all types of outpatient appointment. Action included investigating a call reminder service, piloting telephone calls to remind patients, and automated text alerts. They wrote to vulnerable patients to ask why they had not attended, to avoid discharging them back to their GP unnecessarily. It was too early in the implementation of the plan to assess impact.

It was not always easy for outpatients to find their way to clinics. Although volunteers waited at reception to help older people find their way around the outpatients area, they could not be available for everyone. Older outpatients told us that because of the variety of waiting areas at the end of corridors, reaching the correct waiting area was sometimes difficult. The ophthalmology clinic had appropriate black on yellow signage and blue door frames to make the layout more visible for people with visually impairments. The hospital had not consulted representatives from interest groups supporting visual impaired patients so there was potential for more improvements. During a five-minute observation of the X-ray queue area adjacent to the fracture clinic area, four separate outpatients of various ages approached the lead nurse to ask for directions or confirm that they were in the right place. We saw evidence that the hospital had a task and finish group aiming to improve signage, and had identified many of the issues. This had not yet led to an action plan.

**Meeting people’s individual needs**

Work was under way to ensure that appointment times were long enough to meet people’s needs. Since our last inspection, increased scrutiny through the RTT assurance meeting and outpatients steering group meant that specialties reviewed issues such as appointment times and new to follow up ratios. For example, we saw evidence that appointment times in the colorectal clinic had been reviewed, for example.

Outpatients services adapted to the needs of bariatric patients. There were bariatric chairs in all waiting areas. Clinics prepared and ensured they had the right equipment in place. For example, the fracture clinic did not have couches suitable for bariatric patients in the plaster room. Instead, they would bring a bed down from a ward when they were notified of a bariatric patient.

Outreach support was offered to local prisons where needed. Two liver clinical nurse specialists visited prisons regularly.

Individual specialities had access to an interpreting service. When staff knew in advance that patients were not fluent in English, they could request a face to face interpreter. They could also access telephone interpreters when they had not had time to plan access to a face to face interpreter in advance. However, we saw evidence that family members were used to interpret for patients on one occasion which could compromise impartiality if consent was needed.

We saw clinic staff taking care of vulnerable users, for example we saw nurses guiding outpatients living with dementia or learning difficulties to bypass clinic queues and to wait in a more private room. We saw evidence that services prioritised these patients.

There was a quiet area where patients could wait if they found busy environments distressing. Nurses showed us a sensory room which was a quiet and relaxing environment.

However, services were not systematically planned to meet the needs of diverse outpatient groups. We saw some reasonable adjustments for patients with disabilities, such as hearing loops and large print, but the outpatient areas had not been recently audited by representatives from disability groups. In some waiting areas we saw nurses call the name of the next patient to be seen and it was possible that an older person with hearing difficulties might not have heard due to background noise. We did not see any signage in languages other than English or any analysis about whether this was needed.

Information was not always tailored to outpatient needs or supplied to people in the right format.
The service did not have a systematic approach to identifying and recording the communication needs of individual outpatients. The system which automatically generated patient letters did not have the facility to send them out in languages other than English or in other formats. We noted that the hospital location map on the reverse side of the patient letter was too small for patients with visual impairments and did not include an internal hospital plan of the outpatients areas. This did not conform to the Accessible Information standard. The service was aware of some of these issues and had started by reviewing whether the size of plasma boards in reception areas made information accessible to patient groups.

The patient appointment system did not include a formal electronic alerting system to flag up the needs of more vulnerable patients. In the case of patients with learning disabilities this was done informally by carers or patients transport, and staff acknowledged that the system could be more robust.

**Access and flow**

Clinicians prepared their clinics in advance to encourage better flow, which was an improvement since our last inspection. This meant that for example, they knew which patients needed scans or diagnostics before their appointment and they organised clinic time accordingly.

Arrangements for monitoring in-clinic wait time had improved and this was enabling outpatient specialties to take action. The hospital electronic patient appointment system (Optims) logged patient arrival times and formally recorded an incident if an outpatient waited for more than 60 minutes. The individual specialty carried out a root cause analysis (RCA) on the logged incident and reported it at an RCA meeting with the deputy chief operating officer every Friday. As a result, specialties took specific actions to reduce delays.

The waiting time for outpatients once they had arrived for appointment had improved since our last inspection. During our 2015 inspection, clinics were running up to two hours late. Clinics we observed this time were running on time or up to 45 minutes late. Data from the hospital’s Optims system showed that the mean time patient main waiting area arrival time and call time to appointment was 38 minutes in July 2018.

Although there were still some issues with overbooking clinics, for example, trauma clinic and other clinics where walk-in patients were added to a completed template, the hospital had governance and performance processes to review these arrangements. Other issues contributed to delays such as lack of consultant availability; all root causes for significant delays were explored. Some significant delays still occurred for example in specialist clinics but overall, delays to patients had been reduced through the RCA process. This was an improvement from our last inspection.

Outpatients services reviewed length of consultation times to align them to patient need, an issue highlighted by our 2015 inspection. The hospital audited colorectal clinics in August 2018 and this showed double booking at all times of day but significant underutilisation of clinic time in the afternoon. This meant that the hospital’s own analysis showed that there was potential to standardise appointment times for patients and to provide more afternoon appointments. The service was developing actions to do this.

Nurses acted to avoid outpatients being inconvenienced if they were booked into the wrong clinic. For example, GPs or booking staff sometimes referred outpatients to the incorrect clinic using Choose and Book. In this case staff would review the outpatient’s notes and accompany the patient to the correct clinic to book them in for the same day, so that their journey would not be wasted. The trust was researching alternative booking systems to resolve this issue.
The service monitored clinic utilisation and developed actions to ensure that clinic space was fully used. The hospital carried out a quarterly audit which analysed unused capacity across all four outpatient areas. This was reported for action within specialties and at outpatients steering group meetings so that specialties could take advantage of any room capacity.

The service offered same day/next day ‘hot clinics’ for emergency patients which avoided delays in regular clinics. Patients were referred from the emergency department or GP or transferred from another hospital. ‘Hot clinics’ ran in ENT, neurology, and ophthalmology. This avoided disrupting planned clinic time for outpatients with booked appointments.

The specialties offered a range of clinics outside of normal working hours. For example, hepatology offered a routine Thursday evening clinic and a new patient clinic on Saturday. ophthalmology had Wednesday and Sunday clinics for glaucoma. Some of these clinics started with the aim of backlog reduction and then became routine.

Specialties used technology appropriately to expand the range of services and meet demand. Ophthalmology were increasing their virtual clinic capacity – for glaucoma, diabetic retinopathy, and for wet macular triage. Nurses used the latest imaging technology and consultants reviewed the results to identify which patients they needed to see. There were telephone clinics for medicine, respiratory and ENT specialties and for pain. Skype clinics were being piloted, for example in neurology where this approach could be used for Parkinson’s patients, among others.

Clinics had arrangements to contact patients with non-standard lifestyles. Members of a local homeless support group Blood Borne Virus (BBV) liaised with homeless people and accompanied them to their hepatology (liver) clinic appointment for example. This support meant that the patients were more likely to attend.

Staff told us that temporary workers were not always easy to contact for appointments although the interpreter could help with this if they had already worked with the patient. We heard that these patients frequently did not attend.

Clinicians sometimes did not have timely access to patient’s test results. In the neurology clinic we saw a consultant seeing an outpatient without the scan being electronically available on the system. The consultant therefore focused on the patient’s own experience and symptoms so that they had an effective follow up appointment based on the patient’s needs.

Outpatients were not always given a choice of appointment time. Patients in ophthalmology, fracture clinic and cardiology, for example, told us they were offered one appointment time, but the appointment offered had been convenient for them. The service did not have an access policy to define access to services for outpatients, including appointments and rules around DNAs.

Although flow had improved across a range of specialties due to pathway changes, patient flow did not always work smoothly in the fracture clinic area. We observed patients standing up to queue for x-ray before their clinic appointment for up to 20 minutes. Booked and walk-in GP referred patients were in the x-ray queue so fracture clinic patients sometimes were not seen in order. The service recognised this and had a fracture clinic task and finish group working on possible solutions.

Referral to treatment (percentage within 18 weeks) – incomplete pathways (Waiting list times)

University Hospitals Birmingham NHS Foundation Trust

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for incomplete
pathways was better than the England overall performance. The latest figures for July 2018, showed 89.5% of this group of patients were treated within 18 weeks versus the England average of 87.3%. Trust data for August 2018 showed that this had improved to 90.7%

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

University Hospitals Birmingham NHS Foundation Trust

Sixteen specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks) between August 2017 and July 2018. The national standard is that the time waited must be 18 weeks or less for at least 92% of patients on incomplete pathways. Eleven specialties met the national standard over the same period.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>99.7%</td>
<td>93.0%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>99.4%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>98.3%</td>
<td>85.3%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>96.5%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>96.5%</td>
<td>92.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.3%</td>
<td>90.3%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>95.7%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>94.3%</td>
<td>84.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>94.2%</td>
<td>89.8%</td>
</tr>
<tr>
<td>Other</td>
<td>94.2%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>93.1%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>91.1%</td>
<td>86.9%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat</td>
<td>90.9%</td>
<td>86.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>90.2%</td>
<td>87.4%</td>
</tr>
<tr>
<td>General surgery</td>
<td>87.6%</td>
<td>84.6%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>83.1%</td>
<td>82.8%</td>
</tr>
</tbody>
</table>
The specialties which did not meet the national standard between August 2017 and July 2018 were urology, ENT, neurology, general surgery and trauma and orthopaedics. Two specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks) between August 2017 and July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>81.1%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>82.8%</td>
<td>88.4%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Overall performance on incomplete pathways declined slightly between August 2017 and July 2018 but was still above the England average. Waiting list time for outpatients varied across specialties. The trust recognised that meeting non-admitted demand, particularly in ophthalmology was key to achieving referral to treatment standard.

The services responded to below average performance by action planning to meet target, an improvement since our last inspection. Ophthalmology non-admitted RTT performance was below average. There was high demand for the services and the specialty recognised there would be a significant shortfall in activity against demand over the next five years if they took no action. They planned additional clinics across a range of sub-specialities including glaucoma and medical retina treatments and had developed business cases to deliver services in the community and in conjunction with partners.

Other underperforming specialties took action to improve performance. For example, neurosurgery planned to provide more appointments using locums and the Smethwick clinic, in August 2018 RTT performance on neurosurgery incompletes fell to 75%, below the target level of 82%. Commissioners had been in the process of designing a new spinal pathway for two years and this had not yet alleviated pressures. The specialty had trained physiotherapists to triage spinal patients to the correct service, and had appointed a spinal surgeon. Additional locum clinics were planned. It was too early to see the revised trajectory when we inspected.

Specialties developed plans to recover backlogs. We reviewed the ENT recovery plan which included virtual clinics and a ‘super clinic’ in October to see 140 patients. The recovery plan would have the effect of boosting performance from 86% in August to 93% in December 2018.

Outpatient and cancer services were affected by the high number of referrals from tertiary centres (other hospitals) where patients had already been on the waiting list. Potentially outpatients had already been waiting near to 18 weeks when they were referred to Queen Elizabeth Hospital.

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

University Hospitals Birmingham NHS Foundation Trust

Performance for people with suspected cancers who were referred urgently was improving. In August 2018 the trust achieved its suspected cancer and breast symptomatic two-week targets for the first time since February 2018. Between January and June 2018, performance declined due to issues such as radiology reporting and the service did not achieve the 93% operational standard.

Specialties acted to turn around declining performance. For example, performance on the breast two-week wait target fell sharply in May 2018. But in July 2018 wait time was reduced from average 21 days to 14 days to first appointment. There was a further four day reduction in wait...
time in October 2018 so that the wait time was 10 days. This represented an improvement of 11 days in the breast cancer pathway.

The service was addressing the challenges to sustainable performance. Turnaround times in radiology, particularly delays in image reporting had been a major factor in performance decline in the six months before our inspection. The service was unable to recruit sufficient radiologists and outsourced some radiology reporting services so that a greater volume could be done quickly. We saw evidence that the outsourcing contractor had arrangements to quality assure its reporting, which included a clinical governance policy, a clinical audit policy and a discrepancy process. In addition, the hospital set a three day turnaround target for its own radiology reporting.

The cancer service performed better than the operational standard of 96% for patients waiting less than 31 days before receiving their first treatment following a diagnosis, for July 2017 to June 2018. With performance of 97.4% the trust performed slightly less well than the England average of 97.5%.

**Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment**

**University Hospitals Birmingham NHS Foundation Trust**

The performance over time is shown in the graph below.

![Graph showing cancer waiting times](image)

Although there was a trend of improvement, for July 2017 to June 2018 the trust performed worse than the 85% operational standard with a rate of 76.0% for patients receiving their first treatment within 62 days of an urgent GP referral. The England average for this time was 82.1%. Trust performance was 79.6% in August 2018. However, at Queen Elizabeth, 65.3% of patients referred by their GPs were treated within 62 days. Leaders informed us that patients referred from other trusts (tertiary referrals) could already have waited a few weeks before they were seen and this had a detrimental effect on Queen Elizabeth RTT treatment times. The service had set up a 104-day harm review meeting to review in detail the care of patients who transferred to Queen Elizabeth from other hospitals.

Cancer pathways action plans focused on reaching the 62-day standard, and improvements on the early part of a patient’s pathway which led to better performance on the two-week wait and 31-day first treatment target also improved 62-day performance. As a result, the first definitive
treatment was more likely to happen within 62 days. For example, the colorectal service planned to send patients straight to test before any consultation, to ensure diagnosis and treatment were timely. This was likely to have a beneficial effect on 62-day performance.

The hospital was improving its response times for outpatients awaiting cancer treatment. Data provided for July to October 2018 showed that the cancer recovery plan had provided 39 more appointments/treatments than originally planned for. It reduced the total number of breaches (where the hospital had not treated the patient within the standard 62-day timescale) from 20 in July 2018 to eight in October 2018.

**Learning from complaints and concerns**

**Summary of complaints**

Complaints were dealt with initially by a nursing sister, then the matron and divisional lead nurse. Senior nurses and clinicians reviewed them at divisional Clinical Governance Group together with action to be taken such as pathway reviews or delivering one-off training around an issue.

From April 2017 to March 2018 there were 44 complaints about outpatients at Queen Elizabeth Hospital. The trust took an average of 30 working days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be resolved within 30 working days.

<table>
<thead>
<tr>
<th>Reason For Complaint</th>
<th>Number Of Complaints</th>
<th>Percentage of Total</th>
<th>Average days to resolve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>12</td>
<td>27.3%</td>
<td>35</td>
</tr>
<tr>
<td>Appointments</td>
<td>9</td>
<td>20.5%</td>
<td>33</td>
</tr>
<tr>
<td>Staff</td>
<td>7</td>
<td>15.9%</td>
<td>25</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>7</td>
<td>15.9%</td>
<td>33</td>
</tr>
<tr>
<td>Waiting times</td>
<td>6</td>
<td>13.6%</td>
<td>21</td>
</tr>
<tr>
<td>Prescribing errors</td>
<td>2</td>
<td>4.5%</td>
<td>32</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>2.3%</td>
<td>28</td>
</tr>
</tbody>
</table>

At the time of production of this report there were three complaints which had been re-opened and remained open.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 199 compliments within outpatients at Queen Elizabeth Hospital. The trust does not supply a breakdown of themes or outpatient specialties.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

**Is the service well-led?**

**Leadership**

Leaders had the skills, knowledge, experience and integrity to respond positively to challenges in the service. Senior nurses, managers and clinicians told us about the challenges to sustainability, quality and performance in their services and the new approaches to address them, such as partnership working to deliver services in the community. Staff told us that leaders were visible and approachable, and that there were clear priorities, such as patient focus and quality, within the service.
Nurses reported to individual specialty matrons and to the outpatients matron in Division C, who dealt with staffing issues such as rotas and recruitment. The outpatients matron reported to the head of nursing in Division C. Medical staff reported through their specialty leads to one of four divisional directors, but there was also a clinical lead for outpatients who was the lead for sexual health.

Since our last inspection, improved governance had given a better structure for local leadership. For example, the RTT assurance meeting and the Friday afternoon RCA meeting promoted a problem-solving culture.

There was a leadership strategy and development programme which included succession planning.

**Vision and strategy**

Leaders told us the vision for outpatient services was a technology based approach with the patient at its centre. The service aimed to meet growing demand by offering different types of clinic which were tailored to patient needs, and did not necessarily have to be located in the hospital. For example, for patients such as neurology patients, it could offer a virtual clinic where the patient did not have to leave home. It could also take services into community locations. This would be supported by MyHealth, an electronic patient record system which had the capacity to store a recording of the patient’s consultation. This would mean that the patient could listen to the recording again if they had could not remember an aspect of their care. The system had been extended to 9937 active users since 2013 and the hospital had piloted video clinics with suitable liver transplant patients so that they could avoid travel time and cost. Digital pathology was also planned which would reduce wait times. Longer term plans included joining up with primary care record systems.

Specialties were working in partnership to develop solutions for local people. For example, there was a joint Birmingham population level business case to develop capacity to treat cataracts with commissioners and Heartlands, Good Hope and Solihull hospitals (HGS) but other stakeholders such as Birmingham Midland Eye Centre (BMEC). The service already worked at community level in Sparkbrook. The new development would be joint QE and HGS clinical facilities and consultant led but optometrist delivered. The vision for ophthalmology included following Royal College recommendations about how to match capacity with demand. (Way Forward project). Cancer services aimed to strengthen links with community services and primary care in their vision to increase services in the community, particularly radiotherapy and less complex care, to avoid excessive travelling for the patient.

Outpatient services also aimed to do as much as possible for the patient within the same visit. For example, if the patients needed pain, liver, renal, and oncology appointments, they could be organised consecutively. The service offered a physiotherapy led service to stream people out of fracture clinic if they did not need to see a consultant. Cancer services were developing more integrated pathways with other services to facilitate the patient journey.

The vision included working with the recently acquired trust in the most effective way possible to meet demand for outpatient specialities and cancer services across Birmingham. Meetings and awaydays were planned to review roles and compare practices.

These initiatives were aligned with the aims of the June 2018 draft trust strategy for UHB and HGS. This highlighted aspirations for the combined trusts such as excellence as a health system and working with partners, standardisation of best practice, clinical service planning across sites, development and roll out of IT systems and making the best use of the hospital estate.
The Outpatients Steering Group monitored progress against the vision and strategy implementation and reported it to the Executive Team and to the Performance Review Meeting.

Each division was performance reviewed by the Director of Performance to monitor how it was progressing against objectives outlined in the vision and strategy.

**Culture**

Staff told us they were supported and respected and their focus was on the needs of the patient. They felt proud to work for the organisation and were keen to inform us about new initiatives.

Leaders and staff representatives were working together to promote a positive new culture since the trust had acquired HGS. This included awaydays for specialities within both trusts to work together to promote the values and encourage team working. Staff were encouraged to talk about concerns and there were Speak Out champions.

The service aimed to retain and increase the skills level of nurses to increase flexibility and keep staff motivated. The higher skilled nursing roles were constantly under review and there were opportunities for more experienced nurses to train to become clinical nurse specialists. Sickness levels especially short-term sickness were highest in unqualified nursing groups. The service was developing plans to improve their long-term career paths and training.

Staff communication was effective. Outpatient nursing teams had monthly team meetings to discuss relevant issues. These included recruitment, outpatient steering group decisions, Friends and Family feedback, a reminder to check resuscitation trolleys and of good handover practice. There was a team brief newsletter with similar content to the team meetings but which reported back on audits such as the pain audit and decisions made at outpatients steering group and reminded staff to do safeguarding, accessible information standard and conflict resolution training.

The trust recognised and celebrated excellent performance. It had Best in Care Awards and in 2017 the pre-screening team in outpatients were nominated.

**Governance**

Governance arrangements around outpatient and cancer wait times had improved since our last inspection. Effective structures, processes and systems of accountability to supported quality and performance. This included weekly trust RTT assurance meeting for outpatients and cancer services, which reviewed performance and backlogs. Individual specialities held waiting list meetings and this information was reviewed at divisional waiting list meetings. This was supported by an improved electronic patient tracking system so there was a shared understanding of where a patient was on their pathway.

Assurance systems were comprehensive and performance issues were escalated through clear channels. The outpatients operational meeting reviewed patient feedback, RCAs due to in-clinic wait times, staffing issues, IT and medical record issues, patient feedback and minutes from the outpatients steering group. The outpatients steering group managed and monitored strategy, change and improvement initiatives within outpatients.

There was effective governance around quality and risk. The Division C Outpatients Specialty Review Meeting reviewed incidents, patient feedback and complaints, and local risk registers. It included an update from triumvirates and Outpatients Steering Group. The Outpatient Steering Group was the forum for change in outpatients and specialties were starting to share good practice. They also reviewed quality and compliance issues and monitored the progress of task and finish groups.
Clinical quality was reviewed effectively. Leaders reviewed clinical quality at divisional clinical quality meetings where risk, demand planning, patient feedback, waiting list detail, complaints and actions taken, risk management, action to be taken under the duty of candour, infection control and compliance with NICE guidelines and clinical audits were discussed. Clinical staff told us there was more openness and honesty in mortality and morbidity meetings since the last inspection.

Levels of governance interacted with each other appropriately. We saw from meeting minutes that groups of leaders communicated effectively with each other about their actions and initiatives.

Cancer services had a monthly harm review meeting to review cases and recognise any themes in order to learn. Commissioners were also informed about harms and learning so they could pass to other hospitals in cases where the outpatient had been referred from another hospital.

**Management of risk, issues and performance**

Leaders identified risk at both strategic and specialty level. For outpatients the key strategic risks were: meeting increasing demand for services; staffing and recruitment, activity levels and finance. Finance had been agreed to fund more qualified nurses in outpatients to mitigate one of these risks; work was ongoing to increase the number of outpatient clinics and make better use of existing capacity.

There were processes in place to monitor current and future performance. Key measures such as Referral to Treatment (RTT) performance, backlog numbers, average wait to appointment time and slot issues were monitored regularly. A reporting structure of meetings reviewed and acted on RTT and cancer performance. Specialties reviewed their performance and reported it divisionally and to a weekly RTT and Cancer assurance meeting and fortnightly Outpatients Delivery Group which reviewed recovery plans, backlogs and needs for clinic space or increased capacity. Specialties reporting to these meetings had increased ownership of performance issues and had to demonstrate actions to solve problems at service level. Issues could be escalated through the outpatient steering group and then to the chief operating officer if needed.

The service used performance monitoring for improvement purposes in addition to assurance. In response to a dip in performance in hospital waiting list times (RTT), the trust developed an RTT improvement plan to address the reasons why they did not achieve the 92% target. This included action such as revised demand and capacity models in all specialties by November 2018 and making the best use of clinic space. Cancer specialities had plans for backlog reduction and to reduce waiting time for first appointments.

Action planning had improved since our last inspection. Specialties had to provide action plans for RTT and cancer assurance meetings if waiting list performance fell below targeted level. This appeared to be a driver for improvement; for example, in October 2018 performance on the breast cancer backlog reduction showed a four day improvement in the pathway, so that patients could expect to be seen in 10 days rather than 14.

Outpatient waiting lists were appropriately monitored and managed. Since our last inspection, the hospital had developed an online patient tracking list so there was a shared understanding between administrators, clinicians and leaders about how to manage the relative risks of waiting patients. There were weekly meetings in specialties to review new and urgent patients, and this information fed into a divisional waiting list meeting, the operational delivery group which was a waiting list problem-solving group and the trust RTT assurance meeting. There were also enhanced tracking meetings within cancer services.

Outpatients and cancer services had task and finish groups which worked on wait times and patient care. For example, a project in urology led to revised pathways for cancer and MRI
scanning patients before making the decision to have a biopsy. This meant that fewer patients underwent the discomfort of a biopsy. This process had been adopted regionally.

Data quality arrangements were improving. Through the RTT improvement plan due for completion in December 2018, the trust was ensuring there was a shared understanding of how to measure RTT and consistent application of associated rules. This included spot checks of patient outcomes to ensure they were recorded correctly.

**Information management**

Information technology systems were used effectively to maintain patient records, and monitor and improve the quality of care. Digital technology was used to produce very detailed images in ophthalmology, for example, which helped clinicians make more accurate diagnoses.

The Optims appointment system was helping to record the time patients spent waiting before they were called in to see the doctor or nurse in outpatients.

The trust developed the MyHealth system where records of consultations could be shared with outpatients with chronic or long-term conditions. This had many potential applications and could improve patient care by providing a recording of the doctor’s or nurse’s advice given during a consultation, which the patient could listen to again if needed.

**Engagement**

Outpatients services had mechanisms to gain feedback and learn from the public. The service held viewpoint sessions with the public, and conducted patient surveys. They had recruited extra phlebotomists to carry out blood testing and located diabetes services in the Nuffield building in response to patient feedback. There had also been changes in endocrinology and plans to take diabetic services out to the community. Engagement with patients about their preferred method of contact was not in place, however.

The trust surveyed its staff regularly and staff contributed to improvement initiatives through task and finish groups. However, team meetings did not include a standing item for staff suggestions.

**Learning, continuous improvement and innovation**

The cancer service and other outpatient specialties had worked with the NHS England ‘Get it right First Time’ team to improve services. This led to comparisons with other centres across the country and an action plan for improvement.

The ophthalmology team was shortlisted for the ‘Best Ophthalmology Team’ in the UK Ophthalmology Awards. This focused particularly on the Uveitis Service, but was applicable across the service. The service received very positive feedback from their patients while putting the submission together.

Many of the outpatient specialties were pioneering initiatives to improve patient care. For example, ophthalmology had obtained funding for the development of a patient glaucoma passport to promote patient adherence to the care plan and manage the condition more effectively. There were plans for a similar diabetic personal health record.

The cancer service was the largest centre participating in the national 100,000 Genomes Project. This aimed to improve cancer care for NHS patients, through tailoring treatment and outcomes through personalised medicine. It involved sequencing DNA from a patient’s tumour and healthy cells and comparing the two sequences. Treatment had not gone live for patients but the service had tumour boards in place.
University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust as it related to the same legal entity. We have used this data to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Details of emergency departments and other urgent and emergency care services

- Queen Elizabeth Hospital – Emergency department and clinical decision unit (CDU)
- Birmingham Heartlands Hospital – Emergency department and ambulatory care
- Good Hope Hospital – Emergency department and ambulatory care
- Solihull Hospital – Ambulatory emergency care

(Source: Routine Provider Information Request (RPIR) – Sites tab)

At Birmingham Heartlands Hospital, the primary care stream consists of a General Practitioner who operates in the department Monday to Friday working six-hour shifts, as well as a ‘GP in ED’ service, which operates from 10am until 10pm on weekdays and 12pm to 8pm at weekends.

There is also an out-of-hours GP deputising service (BADGER) operating from Birmingham Heartlands Hospital from 6.30pm to 10.30pm Monday to Friday and 10am to 10pm at weekends and Bank Holidays. Patients can be transferred to this service following initial assessment if they meet the agreed criteria. A clinical navigator was based in the minors department at Birmingham Heartlands Hospital from 7am to 7pm. The clinical navigator reviews all ambulant patients presenting in minors to triage patients to ensure the patient is seen in the correct stream for their clinical needs.

(Source: Acute PIR – Context acute QEB / Context acute HGC tabs)

The emergency department (ED) and paediatric ED at Birmingham Heartlands Hospital provide services 24 hours a day, seven days a week. There were approximately 110,000 attendances per year. From April 2018 to September 2018, ED at Birmingham Heartlands Hospital had 23,407 attendances in the major’s area and 25,791 attendances in the minor’s area.

The ED had a paediatric emergency department, which was open 24 hours a day, seven days a week. From April 2018 to September 2018, From April 2018 to September 2018, BHH ED
paediatrics department saw 14,751 children under the age of 18.

The main ED majors A area consists of a resuscitation area with five resuscitation bays, majors B has nine cubicles, six assessment cubicles and four high dependency cubicles.

The ED also has an eight-bedded clinical decisions unit (CDU) used for on-going assessments treatment and observations of patients for up to 24 hours.

ED at Birmingham Heartlands Hospital was last inspected by CQC in October 2016 as part of the comprehensive hospital inspection programme. ED was rated as requires improvement overall. As this service was then under a different provider, we cannot compare the ratings for the previous inspection with those ratings.

We conducted an unannounced inspection of the emergency department at Birmingham Heartlands Hospital on 16 to 19 October 2018.

During our inspection, we spoke with 55 members of staff including leaders of the service, consultants, matrons, health care assistants and domestic staff. We also spoke with four ambulance crew.

We spoke with 18 patients and four relatives present in ED during our inspection.

We observed handovers where staff discussed patients’ care and treatment. We reviewed 21 patient records including patient prescription charts and information displayed on huddle boards and noticeboards positioned throughout the department. We also reviewed information regarding the service received from the trust during and following the inspection.

**Activity and patient throughput**
The activity levels in ED at Birmingham Heartlands Hospital were usually high. Senior staff told us the department would regularly see 100 patients per day in the department. During the week before our inspection, the ED had seen 156 in the department in one day.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity, we have used this to form part of our judgement.

From August 2017 to July 2018, there were 216,385 attendances at the trust’s urgent and emergency care services as indicated in the chart above. Of these 201,607 were type 1 and 14,778 were type 3.

*Please note:* This includes attendances for April to July 2018, which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.

**Total number of urgent and emergency care attendances at University Hospitals Birmingham NHS Foundation Trust compared to all acute trusts in England, August 2017 to July 2018**
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018, there were 179,805 attendances at the trust’s urgent and emergency care services as indicated in the chart above. Of these 153,728 were type 1 and 26,077 were type 3.

Total number of urgent and emergency care attendances at Heart of England NHS Foundation Trust compared to all acute trusts in England, August 2017 to March 2018

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

Heart of England NHS Foundation Trust
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The percentage of A&E attendances at this trust that resulted in an admission remained similar between 2017/18 and 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity, we have used this to form part of our judgement.

Urgent and emergency care attendances by disposal method, from June 2017 to May 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>37,001</td>
<td></td>
</tr>
<tr>
<td>Discharged*</td>
<td>62,437</td>
<td></td>
</tr>
<tr>
<td>Referred*</td>
<td>12,627</td>
<td></td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,410</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>192</td>
<td></td>
</tr>
<tr>
<td>Left department#</td>
<td>4,382</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>342</td>
<td></td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no
more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

**Urgent and emergency care attendances by disposal method, from June 2017 to May 2018**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>76,862</td>
</tr>
<tr>
<td>Discharged*</td>
<td>158,481</td>
</tr>
<tr>
<td>Referred*</td>
<td>12,600</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>19,768</td>
</tr>
<tr>
<td>Died in department</td>
<td>363</td>
</tr>
<tr>
<td>Left department#</td>
<td>5,437</td>
</tr>
<tr>
<td>Other</td>
<td>155</td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory Training**

The service did not provide mandatory training in key skills to all medical staff and did not ensure everyone completed it.

Not all medical staff were up-to-date with their mandatory training for safety systems, practices and processes. Mandatory training was comprehensive and met the needs of patients and staff. The training combined face-to-face and online training and included a variety of modules designed to keep patients and staff safe and supported staff to conduct their role effectively. Most nursing staff were up-to-date with their mandatory training. All modules had completion rates of over 80%. The trust’s 90% completion target was met for nine of the 12 mandatory training modules for which qualified nursing staff were eligible. Medical staff met the BHH mandatory training target of 90% for four of the 12 modules. 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.

**Mandatory training completion rates**

**Birmingham Heartlands Hospital**

A breakdown of compliance for mandatory training courses from April 2018 to June 2018 for nursing staff in urgent and emergency care at Birmingham Heartlands Hospital is shown below:
The trust's 90% completion target was met for nine of the 12 mandatory training modules for which qualified nursing staff were eligible. The clinical resuscitation module had the lowest completion rate at 83.2%.

A breakdown of compliance for mandatory training courses from April 2018 to June 2018 for medical staff in urgent and emergency care at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2018 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>125</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>125</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>125</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>124</td>
</tr>
<tr>
<td>Information Governance</td>
<td>123</td>
</tr>
<tr>
<td>Waste Management</td>
<td>121</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>120</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>117</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>114</td>
</tr>
<tr>
<td>Manual Handling - Patient Handling</td>
<td>112</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>107</td>
</tr>
<tr>
<td>Resuscitation - Clinical</td>
<td>104</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for four of the 12 mandatory training modules for which medical staff were eligible. The waste management module had the lowest completion rate at 45.9%.

The trust’s 90% completion target was met for four of the 12 mandatory training modules for which medical staff were eligible. The waste management module had the lowest completion rate at 45.9%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Although the mandatory training data showed nursing and medical staff had not met the trust target for clinical resuscitation training, staff told us they had completed basic life support and where required, advanced life support training, including paediatric life support training. The ED service’s data return showed low completion rates for the resuscitation training module and did not include staff training compliance for advance life support and paediatric life support training rates. Senior staff were aware of mandatory compliance rates. They told us the service was in...
the process of recruiting two additional ED consultants with the aim of relieving the medical staffing pressures the department was suffering. Senior staff hoped this would enable more staff to attend their mandatory training days and increase compliance rates. However, this would still be dependent on the activity levels in ED and the staffing levels at the time.

ED staff had conducted sepsis training to ensure they were competent to use the sepsis six screening tool and sepsis care bundles. This training combined online and face-to-face modules. 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 modified early warning scores (MEWs) and paediatric early warning scores (PEWs) records we checked.

Staff completed some dementia training in the trust’s corporate induction. We saw staff could attend dementia study days to increase their dementia awareness. Birmingham Heartlands Hospital had a dementia lead to provide additional advice and support to ED staff. The department was in the process of implementing the nationally used ‘this is me’ passport for dementia patients. This included individualised patient information including their cultural and family background, personal preferences and regular routines.

(Source: Routine Provider Information Request (RPIR) and DR179)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, staff were not always up-to-date with their safeguarding and PREVENT training on how to recognise and report abuse and vulnerabilities.

Nursing staff were up-to-date with two of the three mandatory safeguarding training. Compliance rates were 100%; this exceeded the trusts 90% target. Nursing staff told us they had completed Safeguarding Level 3 Children Core Knowledge training however, the trust’s training data received showed no nursing staff were either eligible or had completed this training.

Safeguarding training completion rates

Safeguarding training included Mental Capacity training. Staff did not currently conduct Deprivation of Liberty Safeguards training; the trust’s safeguarding team planned to implement this training.

Safeguarding

Safeguarding training completion rates

Birmingham Heartlands Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to June 2018, for qualified nursing staff in urgent and emergency care at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2018 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 1 Children and Adults</td>
<td>125</td>
</tr>
<tr>
<td>Safeguarding Level 2 Children and Adults</td>
<td>35</td>
</tr>
<tr>
<td>Safeguarding Level 3 Children Core Knowledge</td>
<td>0</td>
</tr>
<tr>
<td>Healthwrap PREVENT</td>
<td>117</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible at 100% compliance.
A breakdown of compliance for safeguarding training courses from April 2018 to June 2018, for medical staff in urgent and emergency care at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2018 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 1 Children and Adults</td>
<td>56</td>
</tr>
<tr>
<td>Safeguarding Level 2 Children and Adults</td>
<td>21</td>
</tr>
<tr>
<td>Safeguarding Level 3 Children Core Knowledge</td>
<td>0</td>
</tr>
<tr>
<td>Healthwrap PREVENT</td>
<td>42</td>
</tr>
</tbody>
</table>

Medical staff were not up-to-date with all of the safeguarding training they were required to complete. The trust’s 90% completion target was met for one of the three safeguarding training modules for which medical staff were eligible. Medical staff told us they had completed Safeguarding Level 3 Children Core Knowledge training however, the trust’s training data received showed no nursing staff were either eligible or had completed this training.

We received further safeguarding training data from the trust following our inspection as shown below. The trust provided data for the total compliance rates for Heartlands Hospital, Good Hope Hospital and Solihull Hospital combined. The trust were unable to provide this data split by hospital site. This showed staff were up-to-date with this training.

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 exceeded the 90% target at 93.6% compliance. Although medical staff did not meet the trust target as compliance was at 68.9%.

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Staff required to undertake the training</th>
<th>Total staff</th>
<th>Number trained</th>
<th>Target</th>
<th>Current Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children &amp; Adults Level 2</td>
<td>HCA’s; Emergency Practitioners &amp; Junior Medics</td>
<td>309</td>
<td>284</td>
<td>85%</td>
<td>92%</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Adults Level 2 within 3 yrs</td>
<td>HCA’s; Emergency Practitioners, Junior Medics, Qualified Nurses &amp; Senior Medics</td>
<td>309</td>
<td>274</td>
<td></td>
<td>89%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>Qualified Nurses &amp; Senior Medics</td>
<td>207</td>
<td>194</td>
<td></td>
<td>94%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 within 3 yrs</td>
<td>Qualified Nurses &amp; Senior Medics</td>
<td>207</td>
<td>189</td>
<td></td>
<td>91%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3 within 3 yrs</td>
<td>Head Nurse &amp; Senior Nurses</td>
<td>4</td>
<td>4</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

The safeguarding team told us ED staff were very responsive to safeguarding training.
Safeguarding supervision was provided to ED and paediatric ED staff. Staff could access further support for safeguarding 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. Staff had the opportunity to attend an adult safeguarding conference in November 2018 to raise staff awareness. This was held on each site. This conference included speakers from the local safeguarding board, local police and fire service and RAID.

The safeguarding team had close links with the local authority and other agencies. This ensured all safeguarding information was shared with all appropriate agencies. The safeguarding team attended multidisciplinary safeguarding meetings such as strategy meetings with external agencies.

The recently implemented youth working team worked closely with the trust’s safeguarding team to support vulnerable young people. The team attended weekly meetings with the safeguarding team to ensure information regarding vulnerable young patients was shared. ED staff used the Child Protection - Information Sharing project system (CPIS) to ensure all safeguarding information was shared across the wider healthcare system. This would also flag on the ED electronic patient record system to ensure all staff were aware of any safeguarding concerns.

The emergency department had formal arrangements in place to safeguard patients with, or at risk of female genital mutilation (FGM). ED staff were supported by the FGM champion from the maternity department if they required specialist input. Safeguarding training included FGM to ensure staff remained up-to-date. The trust’s safeguarding policy also included FGM advice.

Staff in ED coordinated with the safeguarding team to support patients who had experienced domestic abuse and protected patients from other patients with history of domestic abuse offences. On one patient records, RAID staff had clearly written in capitals that the patient was a high risk to females. Domestic violence leaflets were available throughout ED. Staff were knowledgeable about domestic abuse. We observed domestic violence was discussed at the medical handover we attended.

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. The paediatric ED staff told us they submitted a large number of child safeguarding referrals.

From April 2017 to March 2018, ED at Birmingham Heartlands Hospital and Good Hope Hospital and the MIU at Solihull Hospital had 538 adult and 1,890 children safeguarding referrals as shown below:

<table>
<thead>
<tr>
<th>AC - Urgent and Emergency Services</th>
<th>36</th>
<th>44</th>
<th>39</th>
<th>42</th>
<th>47</th>
<th>54</th>
<th>40</th>
<th>44</th>
<th>43</th>
<th>44</th>
<th>53</th>
<th>HGS acute Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Urgent and Emergency Care</td>
<td>148</td>
<td>153</td>
<td>191</td>
<td>185</td>
<td>202</td>
<td>165</td>
<td>155</td>
<td>161</td>
<td>111</td>
<td>121</td>
<td>130</td>
<td>168</td>
</tr>
</tbody>
</table>

Total of: adult referrals: 538

Total of child safeguarding referrals: 1,890
We requested the safeguarding referral figures specifically for ED at Birmingham Heartlands Hospital. However, the trust provided combined data for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

Staff and the trust’s safeguarding team told us how there had been an increase in the number of safeguarding concerns raised over recent years. Staff told us this was due to the deprived demographics of the local region in addition to an increase in staff awareness. The safeguarding team would follow up directly with staff where there was insufficient information included in the safeguarding referral and provide support and training if necessary. Staff from the trust’s safeguarding team told us the ED were the biggest referrers.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

From April 2018 to June 2018, there were no reported cases of Methicillin-resistant Staphylococcus aureus (MRSA) in ED at BHH against a trust target of zero.

Infection prevention and control (IPC) measures were in place across ED. This was to ensure patients were protected against hospital-acquired infections when treated in the department. Staff adhered to the trust’s infection, prevention and control policy and were bare below the elbow.

Following our inspection, we received the care indicator results summary with combined results for Heartlands Hospital, Good Hope Hospital and Solihull Hospital. From March 2017 to September 2018, the combined emergency department results ranged from 92% to 97% for environment including infection control, availability of hand gel, cubicle cleaning between patients and cleaning of resuscitation areas. We had submitted a document request infection control audit results for ED at Birmingham Heartlands Hospital however the trust did not provide this data.

The ED service was promoting hand hygiene throughout the ED. Sanitizing gel was positioned at all entry points for use by the public and staff. Illustration posters encouraged members of the public to cleanse their hands on entry to the department. We saw staff gelled and washed their hands between each patient contact. Staff disposed of waste appropriately; staff disposed of single use items in dedicated sharps bins. ED waiting areas all had wipe-clean seats.

Staff wore personal protective equipment (PPE) when required. We saw PPE was readily available for use, such as disposable gloves and aprons.

All areas of the department were visibly clean and tidy. Domestic staff told us they worked well together with other ED staff to ensure the ED was kept clean and tidy. Some equipment had ‘I am clean’ tags attached to demonstrate the cleaning was up-to-date. However, we did not see this system in place across all of ED. The kitchen in CDU was well organised and all surfaces were free from food debris.

Play specialists were responsible for cleaning toys in the ED paediatric waiting area each day. We saw the toy cleaning monitoring form was fully completed for all dates in October 2018. However, this form was in a wipe-able format where each month’s entries were removed at the start of each new month to start a new record. Therefore, the service did not have any permanent records available to evidence staff had appropriately cleaned toys each day.

Environment and equipment
The service maintained the ED premises and equipment and looked after them well. Staff had sufficient access to emergency and specialist equipment for all patient groups.

Resuscitation equipment was fully equipped, regularly reviewed and adequately stocked in the event a patient should urgently require resuscitation.

The 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 had to staff each individual area of ED. The minors department had been relocated into the previous fracture clinic in an attempt to increase capacity of the ED.

The layout of the paediatric ED was fit for purpose. The department was segregated from the main ED corridor area by lockable doors accessible to authorised staff with swipe card access. This department was also accessible to patients and relatives by a separate entrance. This department consisted of a dedicated paediatric reception area, a child friendly waiting area and assessment cubicles.

The department was situated nearby to some other clinical areas. CT scanning and MRI areas were next to ED should patients need transferring there for tests. However, the theatres were a distance from the ED.

The majors and minors waiting areas had sufficient seating areas for patients and relatives. Each area of the department had male and female toilets. However, on our first day of inspection we noted three toilets across the department were out of order. When we returned to check the following day, all toilets were back in use.

Equipment checks overall were up-to-date. However, we saw a blood pressure monitor with checks due in September 2018. We escalated this with senior staff during the inspection who arranged with the medical devices department to ensure checks were conducted. This was also mentioned at the staff handover to highlight to staff.

Security staff provided support to staff and patients on site, 24 hours a day, seven days a week. A security guard was always present in the minor’s area of ED. We saw security staff assisted clinical staff by supervising patients with challenging behaviour. Staff told us security staff were always responsive and attended quickly when required. The ED also had direct access to the local police.

The department was clearly signposted to assist patients and visitors to find the separate areas of the ED. However, we saw a number of visitors asking staff for directions during the inspection as they 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 were planning to recruit volunteers to help signpost patients.

There was a dedicated mental health room available in the emergency department, which the RAID team used to assess patients with mental health concerns. Staff were able to monitor patients in this room, as there was CCTV.

Staff in the emergency department were prepared for major incidents. We saw information displayed in the ED staff seminar room in the department, which identified staff roles in the event of an emergency. Staff understood the major incident arrangements and told us a recent major incident drill had been carried out in ED to replicate major incidents, which had occurred in other parts of the UK. This identified where things went well, such as consultants at Good Hope Hospital being able to view the ED screen in case patients needed to be transferred. Senior staff in ED
attended regional network meetings with other stakeholders in the trauma network to discuss major incident planning and resilience.

Staff were proactive in ensuring the paediatric department was functional as soon as possible following a flood in June 2017. Staff had co-ordinated together with other hospital departments to ensure children could be treated elsewhere in the hospital.

**Assessing and responding to patient risk**

**Staff identified and responded to changing risks to patients, including deteriorating health.** However, the lack of patient information in other languages did not support patients and relatives to monitor signs of deterioration.

The service did not always provide suitable information to patients and relatives for them to adequately monitor their condition once discharged home. We had concerns regarding information provided to patients with head injuries, which formed a large proportion of ED attendances. The leaflet was only available in English and provided advice for closely monitoring a relative for 48 hours for specific symptoms. If patients or relatives did not understand the advice provided they might not recognise any dangerous symptoms requiring ED admission.

We saw clear evidence staff used the sepsis six screening tool throughout the ED. Staff had appropriately recorded and monitored patients for signs of sepsis in the 21 patient records we reviewed. We observed a patient who had been identified with sepsis received treatment within the recommended 60 minutes. Staff were knowledgeable about reviewing patients for signs of sepsis and deterioration. Paediatric ED staff used a dedicated paediatric sepsis tool introduced in June 2018 in collaboration with a local children’s hospital. Staff conducted regular sepsis audits for paediatric patients. The ED used an automatic antibiotic alert bleeps to provide a prompt to nursing staff to ensure that antibiotics were administered in a timely way. The service audited this and addressed non-compliance with senior leaders and the implementation of an improvement action plan.

Senior ED staff reviewed the Commissioning for Quality and Innovation (CQUIN) sepsis requirements and recommended areas for improvement and development. CQUIN is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. We requested sepsis audit results and associated action plans specific to Birmingham Heartlands Hospital for the last 3 months as DR175. The trust was unable to provide this as Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital figures were not currently reported by site. However, we saw evidence the service had learned from audit results to improve the detection and management of sepsis patients. This was in conjunction with the implementation of the new Trust Sepsis Strategic group.

ED staff appropriately completed the National Early Warning Scores (NEWS) and Paediatric Early Warning Score (PEWS) in line with the trust internal policy. We reviewed 13 adults and five child observation charts. Staff had performed and recorded observations appropriately in each of these records. We saw evidence staff had suitably escalated patients in response to patient deterioration in line with the trust guidance. The department had staff NEWS and PEWS competencies in place to show staff were competent. The trust was in the process of implementing NEWS2 to be in line with the Queen Elizabeth Hospital policies.

ED staff handovers with ambulance crew for patients arriving into the department by ambulance were appropriate. ED corridor nurses (Band five registered nurse) supported by a health care assistant received the handover of patients from ambulance crew mainly in the ED corridor or in a cubicle if one was available. Staff ensured patients were moved to cubicles as soon as one became available. Paramedics informed us that ED staff used to wear orange armbands to easily identify which member of staff to go to for patient handover. They told us this had been useful for ambulance crew however, they had not seen staff using them recently. We did not observe staff
wearing these armbands during our inspection.

Nursing and clinical staff including two ACP’s staffed the Rapid Assessment and Treatment (RAT) area to ensure patients were appropriately triaged. Staff used a coded coloured triage system to determine the priority for patients to be reviewed or assessed and patients awaiting tests. Rapid Assessment and Treatment (RAT) is the process where staff conduct a rapid patient assessment to determine what investigations, tests and immediate treatment patients need on arrival in ED.

The service ensured patients were referred to the Clinical Decisions Unit (CDU) from the emergency department in accordance with the emergency department standard operating procedure (SOP). CDU is the observational medicine area for the ED for patients awaiting investigation or treatment that would take less than 24 hours. The CDU was led by a consultant with one staff nurse, one health care assistant and one trainee consultant from 8am to 4pm. The referral process to the CDU from ED involved a discussion between ED staff and the consultant in the CDU to ensure patients met the specific criteria outlined in the SOP. The staff in the Clinical Decision Unit (CDU) appropriately reviewed patients. Patients were not transferred to other areas of the hospital or discharged home or back to the community until a consultant had reviewed them and agreed the transfer.

The department had clear patient pathways in place. These pathways included paediatric, CDU 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.

Staff worked closely with the trust’s Rapid Assessment Interface and Discharge (RAID) mental health team to support patients with mental health concerns. The RAID team assessed, diagnosed and managed patients aged over 16 years who attended ED with mental health concerns including suicidal tendencies.

A recently implemented youth worker service worked closely with the trust’s RAID team to further support young patients. The team was integrated into the department to provide support to vulnerable young people aged 11 – 24 years. The team consisted of a team leader, programme co-ordinator and two youth workers who covered 7am to 9pm, Monday to Friday. Staff were aware of this service and gave examples of escalating and sharing information regarding concerns of gang involvement. Staff were responsible for signposting suitable patients to this service. We saw posters displayed throughout the department advertising the service to staff with contact numbers. There was evidence of engagement with staff; the youth worker team contacted staff directly to thank them for their referrals. The youth workers attended staff inductions to ensure staff were aware they could refer patients presenting with concerns. The service monitored the number of referrals they received each week, which had been approximately 90 patients. The service monitored their own performance and provided reports to show any impact the service was having.

Following the inspection, we received the following ED metrics from March 2018 to October 2018 for Birmingham Heartlands Hospital:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>March 18</th>
<th>April 18</th>
<th>May 18</th>
<th>June 18</th>
<th>July 18</th>
<th>August 18</th>
<th>September 18</th>
<th>October 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resus Checklist</td>
<td>100%</td>
<td>88%</td>
<td>71%</td>
<td>100%</td>
<td>67%</td>
<td>88%</td>
<td>67%</td>
<td>62%</td>
</tr>
<tr>
<td>Allergy Status Signed</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
<td>100%</td>
<td>86%</td>
</tr>
<tr>
<td>IV fluids</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
<td>RAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait</td>
<td>6.6</td>
<td>About the same as other trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
before being examined by a doctor or nurse?

Q33. In your opinion, how clean was the emergency department?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.5</td>
<td></td>
</tr>
</tbody>
</table>

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9.7</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust has submitted the below figures for the median time from arrival to initial assessment for August 2017 to March 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>University Hospitals Birmingham NHS Foundation Trust</th>
<th>Former Heart of England NHS Foundation Trust sites</th>
<th>Trust Total</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>0</td>
<td></td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Sep-17</td>
<td>1</td>
<td></td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Oct-17</td>
<td>0</td>
<td></td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Nov-17</td>
<td>0</td>
<td></td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Dec-17</td>
<td>0</td>
<td></td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Jan-18</td>
<td>1</td>
<td></td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Feb-18</td>
<td>0</td>
<td></td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Mar-18</td>
<td>0</td>
<td></td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Apr-18</td>
<td>0</td>
<td>18</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>May-18</td>
<td>0</td>
<td>20</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>Jun-18</td>
<td>0</td>
<td>20</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Jul-18</td>
<td>0</td>
<td>21</td>
<td>21</td>
<td>8</td>
</tr>
</tbody>
</table>

Data from April 2018 was still being submitted using the trust code for Heart of England NHS Foundation Trust up to (and including) July 2018.

However, BHH ED did not always meet the standards for caring for patients promptly. We saw patients were not always seen within the recommended 15 minutes for a face-to-face assessment once they had been registered into the department.

Median time from arrival to initial assessment (emergency ambulance cases only):

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

DR163 - Median Time from Arrival to Initial Assessment (Minutes)
The median time from arrival to initial assessment was worse than the overall England median from August 2017 to March 2018 as shown below:

Ambulance – Time to initial assessment from August 2017 to March 2018 at Heart of England NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes at Birmingham Heartlands Hospital

From April 2018 to July 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Birmingham Heartlands Hospital.

Ambulance: Number of journeys with turnaround times over 30 minutes – Birmingham Heartlands Hospital
We monitored ambulance transfers during the inspection. All handovers we observed were conducted within 15 minutes from patients arriving into the department to being handed over to ED staff for their initial assessment.

Triage times for Birmingham Heartlands Hospital for July 2018 – September 2018 are shown below:

<table>
<thead>
<tr>
<th></th>
<th>Total n</th>
<th>Time to Triage &lt;15mins</th>
<th>Time to Triage 15-30mins</th>
<th>Time to Triage 30-60mins</th>
<th>Time to Triage &gt;60mins</th>
<th>Time to Clinician &lt;60mins</th>
<th>Time to Discharge &lt;4hrs</th>
<th>Left before being seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majors</td>
<td>2348</td>
<td>42.60%</td>
<td>13.30%</td>
<td>18.70%</td>
<td>25.40%</td>
<td>24.10%</td>
<td>49.00%</td>
<td>7.24%</td>
</tr>
<tr>
<td>Minors</td>
<td>3414</td>
<td>48.90%</td>
<td>15.80%</td>
<td>20.40%</td>
<td>14.90%</td>
<td>35.90%</td>
<td>87.90%</td>
<td>9.10%</td>
</tr>
<tr>
<td>Paeds</td>
<td>2416</td>
<td>64.80%</td>
<td>23.50%</td>
<td>9.50%</td>
<td>2.40%</td>
<td>36.50%</td>
<td>90.30%</td>
<td>8.10%</td>
</tr>
</tbody>
</table>

(Source: DR338)

Paediatric patients were mostly seen within 15 minutes. Although, 42.60% of majors patients and 48.90% of minors patients were seen within 15 minutes.

Children had their pain assessed and recorded within 15 minutes. We checked five emergency department paediatric records. All five children had received pain relief within 15 minutes.

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Birmingham Heartlands Hospital
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital

From August 2017 to March 2018, there was an overall upwards trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Birmingham Heartlands Hospital.

Ambulance: Number of journeys with turnaround times over 30 minutes – Birmingham Heartlands Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Birmingham Heartlands Hospital
During our inspection, we saw patients arriving into the hospital with ambulance crew were handed over promptly. We spoke with four ambulance crews; they told us the length of time it took to offload patients and hand them over to the corridor nurse and for initial assessments was variable.

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

**Trust level**

From April 2017 to March 2018, the trust reported 218 “black breaches”. There is an overall upwards trend, with spikes in September 2017 (42 black breaches) and January 2018 (48 black breaches).

**Birmingham Heartlands Hospital**

From April 2017 to March 2018, the hospital reported 70 “black breaches”. Numbers were generally low with a spike of 29 breaches in January 2018.
From April 2018 to September 2018, the percentage of patients admitted, transferred or discharged within four hours ranged from 73.90% in September 2018 to 82.00% in August 2018 as shown below:

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>77.50%</td>
<td>81.50%</td>
<td>78.90%</td>
<td>80.20%</td>
<td>82.00%</td>
<td>73.90%</td>
</tr>
</tbody>
</table>

(Source: DR168)

From April 2018 to September 2018, the percentage of patients waiting more than four hours from the decision to admit until being admitted ranged from 4.34% in July 2018 to 7.62% in April 2018, as shown below:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>7.62%</td>
<td>6.48%</td>
<td>6.20%</td>
<td>4.34%</td>
<td>5.70%</td>
<td>6.18%</td>
</tr>
</tbody>
</table>

(Source: DR169)

From April 2018 to September 2018, the median total time patients spent in BHH ED ranged from 166 minutes in August 2018 to 181 minutes in September 2018.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>169</td>
<td>167</td>
<td>169</td>
<td>176</td>
<td>166</td>
<td>181</td>
</tr>
</tbody>
</table>

Source: DR170

From April 2018 to September 2018, there were no patients at BHH ED who had to wait over 12 hours from the decision to admit until being admitted as shown below:

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
**Nurse staffing**

The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

However, during our inspection we saw nursing staffing levels were appropriate. The nurse to patient ratio in majors B of ED at BHH was one nurse to three patients.

Senior staff ensured there was at least one member of staff on shift who was trained in Paediatric Immediate Life Support (PILS). This was to ensure there were staff on each shift competent to provide emergency treatment to children in cardiac arrest.

During our inspection, the ED paediatric department met the required staffing levels for registered children nurses in line with national guidance. There were two Registered Children’s Nurse Practitioners (RCNP) during the day and night shift plus a RCNP on the twilight shift. However, some paediatric ED staff told us they felt staffing was very stretched especially at night if the twilight shift was not covered. Staff had concerns patient safety may be affected due to the staffing levels. We discussed this with senior staff who were aware of the staffing pressures in the department. Staffing problems had worsened as two staff were currently on maternity leave. Senior staff demonstrated where there had been staffing shortfalls, the escalation policy would be instigated and nurses from the main ED with children's competencies were used to support staffing in paediatrics. Senior staff were due to hold interviews to fill Band 5 posts.

Senior staff regularly reviewed and had oversight of the staffing levels in the ED. Senior staff held telephone calls twice a day to discuss staffing across the ED.

Paediatric ED had two Band 5 vacancies. Senior leaders had plans in place to fill these roles as soon as possible.

The service had plans to improve staffing levels in the department. The service had a rolling recruitment plan, which was well supported by the trust board, as they understood the staffing risks. Senior leaders told us the ED staffing shortages were part of a trust plan not just a local plan.

The staffing numbers at BHH for March 2018 and June 2018 for qualified nursing staff in urgent and emergency care is shown below:

The overall fill rate for qualified nursing staff dropped from 87.9% in March 2018 to 77.3% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>129.5</td>
<td>161.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)
Nursing staffing vacancy rates were high in ED. The service was actively recruiting to help address the staffing shortfalls.

From April 2017 to March 2018, the vacancy rate for nursing staff in urgent and emergency care at BHH was 21.7%. this was much higher than the BHH ED target of 5%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Senior leaders were aware nurse staffing in ED at BHH was a challenge. The department currently had 20 new starters planned to fill nursing staffing vacancies between October 2018 and December 2018. However, this meant there were still 20 nursing vacancies remaining in ED following this recruitment.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>275.5</td>
<td>285.6</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>129.5</td>
<td>165.1</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>59.8</td>
<td>76.5</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>34.0</td>
<td>43.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Senior ED staff were proactive to improve staff retention levels. They worked with the communications team to determine what people were looking for when applying. Staff produced podcasts and videos with the aim of creating a clear department brand to sell the team to prospective employees.

Turnover rates
Nursing staff turnover rates in the department was higher than the target. Senior staff in the department were active in addressing staff retention.

From April 2017 to March 2018, the turnover rate for Birmingham Heartlands Hospital was 14.1%. This is above the BHH target of 8.5%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

The staff turnover rate was above the Birmingham Heartlands Hospital target. However, senior staff demonstrated they were aware staff retention in the department was a challenge. The service had plans in place to improve turnover rates such as by growing their own staff. For example, some Band 5 and Band 6 staff were conducting two-year preceptorship programmes to prepare them for Band 6 and Band 7 roles respectively. We also spoke with some long-serving staff and staff who had left and returned to work at BHH.

Sickness rates
From April 2017 to March 2018, qualified nursing staff sickness rates for Birmingham Heartlands Hospital were slightly above the BHH target of 4.6% at 4.2%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
**Bank and agency staff usage**

The ED at BHH used a regular set of bank and agency staff to fill unfilled shifts. These staff had completed a trust induction and were familiar with the running of the ED. The service had 12 permanent agency staff. Adult nurses with children competencies rotated into the paediatric ED.

Senior paediatric ED staff monitored the number of bank shifts staff covered. This was to ensure staff did not become worn out. The ED had a closed social media group to communicate to their own staff first when bank shifts became available.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From April 2017 to March 2018, the trust reported agency staff filled 3,075 shifts, bank staff filled 16,830 and 11,578 shifts were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>851</td>
<td>12,033</td>
<td>7,850</td>
</tr>
<tr>
<td>Other sites</td>
<td>2,224</td>
<td>4,797</td>
<td>3,728</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

From April 2017 to March 2018, the trust reported that for qualified and unqualified nursing staff 8.2% of actual hours were filled by agency staff and 20.2% by bank staff across Birmingham Heartlands, Good Hope and Solihull hospitals. The number of unfilled hours, a breakdown by site and staffing type was not provided.

(Source: Nursing bank agency - HGS PIR Return)

**Medical staffing**

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. There was consultant cover in the emergency department for 14.5 hours a day, which did not meet 16 hours medical staffing cover as recommended by the Royal College of Emergency Medicine.

The service did not meet the Royal College of Emergency Medicine (RCEM) guidance which recommended the service had 25 consultants. The service had 20 consultants that worked across all of the ED hospital sites. However, updated RCEM recommendations had only been published in September 2018, a few weeks before our inspection. Although the service did not meet the RCEM requirements, the ED had an ST4 or equivalent in ED at Birmingham Heartlands Hospital 24 hours a day, seven days a week.

Consultants started at 8am and were rostered until 10.30pm. Staff told us the late shift consultant rarely left at 10.30pm and would often finish as late as midnight. This coverage would meet the recommended 16 hours cover. However, this was not a formal arrangement and depended on the good will of consultants to go beyond to cover the additional hours.

Staff told us medical staffing levels in the paediatric ED was a concern. The paediatric ED had one Band seven consultant compared to 10 Band seven consultants covering the main ED.
Leaders of the service had identified medical staffing levels as a concern for the service, which was recorded as a red risk on the risk register. This identified insufficient number and skill mix of junior and middle grade staff which could affect quality and safety of patient care. However, the ED had a well-established advanced care practitioner (ACP) role to support medical staffing levels and support junior doctors. ED had 10 ACPs in post who were used to cover the junior or middle grade medical staffing rota depending on experience.

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in urgent and emergency care.

The overall fill rate rose from 82.6% in March 2018 to 90.8% in June 2018. However, the staffing data for June 2018 for Queen Elizabeth hospital shows a rise of around 530 members of medical staff. This has been queried with the trust.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>70.9</td>
<td>72.5</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>57.2</td>
<td>81.4</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>8.0</td>
<td>11.0</td>
</tr>
</tbody>
</table>

The trust reported no medical staff for urgent and emergency care at Solihull Hospital.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The staffing numbers for BHH for March 2018 and June 2018 for medical staff in urgent and emergency care is shown below:

The overall fill rate for medical staff dropped from 83.0% in March 2018 to 76.8% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>57.2</td>
<td>80.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

As at September 2018, the medical staff funding at BHH for medical staff is shown below:

(Source: DR177)

Vacancy rates
Vacancy rates
We requested the establishment and skill mix split specifically for BHH. However, the trust were unable to provide this and submitted data for all three sites combined, Good Hope Hospital, Heartlands Hospital and Queen Elizabeth as shown below:

(Source: DR177)

Medical staffing vacancy rates were high in ED. The service was actively recruiting to help address the staffing shortfalls.

From April 2017 to March 2018, the trust reported a vacancy rate of 21.9% for medical staff in urgent and emergency care.

The breakdown for Birmingham Heartlands Hospital was 24.6%, which was much higher than the target of 10% for Birmingham Heartlands Hospital.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From April 2017 to March 2018, the trust reported a turnover rate of 13.1% for medical staff in urgent and emergency care. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors turnover for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:
- Queen Elizabeth Hospital: 6.7%
- Birmingham Heartlands Hospital: 18.0%

No data was supplied by the trust for medical and dental staff turnover rates at Good Hope Hospital.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 1.0% for medical staff in urgent and emergency care. This is below the trust targets of 3.6% for Queen Elizabeth Hospital, and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 0.2%
- Birmingham Heartlands Hospital: 1.9%
- Good Hope Hospital: 0.5%

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and locum staff usage**

ED used bank and locum consultants to cover the medical rota. They had received an induction and as they were regularly used by the trust, they were aware of the ED’s policies and procedures.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format, we will be able to populate the analysis to complete this section.

From April 2017 to March 2018, the trust reported that 6,179 shifts were filled by locum medical staff, 4,194 by bank medical staff and that 861 were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Locum</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>1,137</td>
<td>1,564</td>
<td>99</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>2,632</td>
<td>1,135</td>
<td>432</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>2,222</td>
<td>1,384</td>
<td>328</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>188</td>
<td>111</td>
<td>2</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)*

**Staffing skill mix**

In May 2018, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average.

**Staffing skill mix for the 102 whole time equivalent staff working in urgent and emergency care at University Hospitals Birmingham NHS Foundation Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>24%</td>
<td>23%</td>
</tr>
</tbody>
</table>
Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
Registrar Group = Specialist Registrar (StR) 1-6
Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

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

Staff appropriately completed patient records. We reviewed 21 sets of patient records during our inspection, which were legible, signed, dated and included appropriate risk assessments and evidence of monitoring patients for deterioration. Records included all relevant patient information and observations had been consistently completed and recorded in all of the records we reviewed.

ED safely stored and managed patient records when in use and following patient discharge. Staff ensured the confidentiality of patient information was maintained.

Medicines

Overall, staff in ED stored and prescribed medicines in line with trust policies and national guidance.

ED staff securely stored and regularly checked controlled medicines. ED staff used an electronic key system to manage staff access to medication. All staff were registered and had their own access code and key. This key system could monitor when staff accessed and removed medication for audit purposes.

The trust’s medicine management team supported pharmacists in ED to ensure medication was readily available to patients. The team also worked closely with nursing and medical staff in ED to ensure patient medication was readily accessible.

ED staff used Patient Group Directions (PGDs) which were appropriately used to give patients access to the medications they needed. Patient group directions allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription.

Staff had accurately recorded patient’s allergies in all of the five prescription records we checked.
Records showed antibiotics had been prescribed to one patient and administered in a timely manner. We saw staff ensured patients with allergies wore a red wristband to clearly identify allergies. We observed staff checked patients’ allergies on this wristband before prescribing further medication.

Following the inspection, we requested the medicines management audit specific to ED at Birmingham Heartlands Hospital for the last three months as part of DR173. The trust was unable to provide this evidence. The trust submitted their care indicator results summary, which contained combined data for Heartlands Hospital, Good Hope Hospital and Solihull Hospital. From March 2017 to September 2018, the combined emergency departments’ results ranged from 92% to 97% for environment. These metrics included intravenous fluids were stored in secured areas, resus bay drugs, daily checking of controlled drugs, medicine fridge temperatures and secure medicine storage and medicine cupboards. The ED worked with the pharmacy team to address areas of non-compliance.

ED had pharmacy support from the trust’s medicine’s management team. The team ensured staff in ED had timely access to patient medication.

(Source: DR173 and DR174)

**Incidents**

**The service managed patient safety incidents well.** Staff recognised incidents 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 in line with the Duty of Candour regulation.

There was a positive incident reporting culture in the department. We spoke with four members of staff about raising incidents. All staff told us they would be comfortable discussing incidents with their immediate team or escalating concerns to their line manager or the nurse in charge. ED matrons conducted walk rounds to ask staff about their understanding of serious incidents and outcomes.

The service had learned from previous incidents in the department. Service leaders had implemented measures to prevent reoccurrence such as reviewing and assessing staff competencies. For example, an ambulance handover sheet had been introduced to improve the handover process. We saw the service had also implemented new policies and reviewed existing policies in response to previous ED incidents.

Staff confirmed learning from incidents in ED was appropriately shared. Staff meeting minutes and the ‘risky business’ newsletter included changes in practice in response to local incidents.

There was a positive incident reporting culture in the department. Staff understood how to report incidents on the trust’s electronic incident reporting system and knew what incidents to report. Staff told us they received feedback from incidents they had reported.

Patients that had passed away within 24 hours and seven days of ED admission were reviewed at mortality and morbidity meetings. This was to review whether patient care in ED had been appropriate. Meetings were held three times a year for paediatric ED and five times a year for ED. Where concerns were identified, themes were monitored and learning shared with staff via newsletters and emails directly to ED staff.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Heart of England NHS Foundation Trust
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust reported one incident classified as a never event for urgent and emergency care occurring from August 2017 to March 2018. This related to a misplaced nasogastric tube and occurred in November 2017 at Birmingham Heartlands Hospital.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

Heart of England NHS Foundation Trust

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England occurring between August 2017 and March 2018.

The breakdown by type of incident reported were:
- Diagnostic incident including delay (including failure to act on test results) with three (37.5% of total incidents)
- Sub-optimal care of the deteriorating patient with three (37.5% of total incidents)
- Slips/trips/falls with two (25.0% of total incidents)

Site specific information can be found below:
- Birmingham Heartlands Hospital (August 2017 to March 2018): four incidents

(Source: NHS Improvement - STEIS)

Safety Thermometer
The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care.

*(Source: NHS Digital - Safety Thermometer)*

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**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Policies were easily accessible on the trust’s intranet; managers checked to make sure staff followed guidance.

ED staff ensured patients were on a suitable patient pathway for their needs. Pathways followed local and national guidance. This included the paediatric ED pathway for children and frail elderly pathways were in place.

Local ED policies and procedures were up-to-date and followed national guidance. Staff could access them on the intranet. The University Hospitals Birmingham NHS Trust were in the process of aligning all policies to ensure consistency across all ED sites.

The ED held effective handovers. Medical and nursing handovers were held twice a day. Local handovers were held after these handovers. These followed the Situation, Background, Assessment, Recommendation (SBAR) format to ensure key information was discussed. We saw outstanding practice at a medical handover we attended; all pertinent patient information was discussed and referred to the psychological and emotional needs of patients. Staff at all levels were confident to challenge one another.

The ED participated in local and national audits. National audits included the Royal College of Emergency Medicine audits. Senior staff ensured actions were taken in response to audit results to improve patient care and treatment when required. BHH ED were coordinating with ED sites across the trust to ensure consistency with ED audits conducted. The 2018 - 2019 audits to be conducted in ED were feverish child, VTE risk in lower limb immobilisation and vital signs in adults. Data collection began in August 2018. Local audits included record keeping, medicines management and sepsis audits.
Staff responded to mental health patients in a timely way. Staff followed the mental health risk assessment for adults. We observed staff and records confirmed staff referred patients to the Rapid Assessment Interface and Discharge (RAID) team to ensure patients received additional mental health support.

**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 preferences.

Provisions were in place to ensure patients and relatives could access food and drink. In the paediatrics emergency department, a trolley held two types of squash and water, enabling children to help themselves. A sign in the minors ED area clearly advertised a vending machine for patients and relatives to access snacks and drinks. Within the majors department, we observed a tea round offering patients tea and coffee. We also observed staff asking patients if they would like a cup of tea.

Staff monitored patients’ individual nutrition and hydration requirements. Staff used a nutritional screening tool to assess a patient’s risk of malnutrition. ED staff provided patients with food to meet a variety of food requirements such as Halal (permissible food and drinks under Islamic Law), vegetarian and softer pureed foods. We saw staff carried out regular comfort rounds for patients offering both hot and cold drinks and snacks. We saw in the clinical decision unit, staff also offered relatives drinks.

The department had made suitable adjustments to support patients who may need feeding support. The clinical decision unit had adapted cutlery, beakers and plates available for patients.

Staff were aware of patient’s food allergies and nutritional needs. In the CDU kitchen, we saw there was a poster highlighting allergens information. We saw a nurse checked the feeding status of a patient before providing them with any food and drink to ensure they were not nil by mouth.

Patient food and drink products were stored in a fridge in the clinical decision unit kitchen. All provisions we checked were in date and appropriately stored. However, the fridge only had an internal temperature monitor in place. There was not a robust system for staff to conduct daily temperature checks and we had concerns staff would not know if food was being stored outside of safe temperature ranges if the fridge became faulty. We raised this with a healthcare assistant who immediately escalated this to senior staff and the estates department.

**Emergency Department Survey 2016**

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

**Pain relief**

**Staff regularly assessed and monitored patient’s pain levels. Staff supported those unable to communicate by using suitable assessment tools and gave additional pain relief to ease pain.**
Staff supported patients with their pain relief needs. Staff were trained to assess and monitor patient’s pain relief requirements. Staff used pain pictorial charts to assess patients’ pain levels. ED had introduced the ‘smiley faces’ system to support non-English speaking patients to communicate their needs more effectively. Patients confirmed staff checked their pain levels on a regular basis. We observed staff responded empathetically towards one patient in the resuscitation area in need of pain relief. They promptly received the pain relief they required.

We spoke with 15 patients in the Emergency Department (ED) (seven adults and eight children) regarding their pain management. All patients who required pain relief had been administered it in a timely way during their initial assessment.

Emergency Department Survey 2016
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the CQC Emergency Department Survey, the trust score for the question “How many minutes after you requested pain relief medication did it take before you got it?” was suppressed.

The trust scored 7.8 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The service had action plans in place to address and monitor areas where improvement was required. Actions were regularly reviewed. Staff also conducted specific audits to further assess results from national audits.

RCEM Audit: Moderate and acute severe asthma 2016/17
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Birmingham Heartlands Hospital emergency department failed to meet any of the national standards of 100%.

The department was in the upper UK quartile for three standards:

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 47.5%; UK: 25%. 
• Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  o Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 40.9%; UK: 19%.

• Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

  This department: 74.7%; UK: 52%.

The department was in the lower UK quartile for one standard:

• Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 12.0%; UK: 26%.

The department’s results for the remaining three standards were all within the middle 50% of results.

• Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 17.5%; UK: 19%.

• Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β₂ agonist bronchodilator therapy. This department: 72.9%; UK: 77%.

• Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  o Standard 5b (fundamental): within 4 hours (moderate). This department: 42.5%; UK: 28%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital

In the 2016/17 Consultant sign-off audit, Birmingham Heartlands Hospital emergency department failed to meet any of the national standards of 100%.
The department was in the upper UK quartile for one standard:

- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 42.6%; UK: 10%.

The department was in the lower UK quartile for one standard:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 4.8%; UK: 11%.

The department’s results for the remaining two standards were within the middle 50% of results.

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 1.0%; UK: 8%.

- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 8.0%; UK: 12%.

(Source: Royal College of Emergency Medicine)

In response to the consultant review of fever in children under 1 year of age, staff conducted regular audits of consultant review of children under the age of five. This included reviewing five patient records each week.

RCEM Audit: Severe sepsis and septic shock 2016/17

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital

In the 2016/17 severe sepsis and septic shock audit, Birmingham Heartlands Hospital emergency department failed to meet any of the national standards of 100%.

The department was in the upper UK quartile for three standards:

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 67.3%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 66.7%; UK: 44.4%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 56.9%; UK: 18.4%.

The department was in the lower UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving
the emergency department. This department: 51.0%; UK: 64.6%.

The department’s results for the remaining four standards were all within the middle 50% of results:

- **Standard 1:** Respiratory rate, oxygen saturations (SaO_2_), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 84.3%; UK: 69.1%.

- **Standard 3:** O_2_ was initiated to maintain SaO_2_>94% (unless there is a documented reason not to) within one hour of arrival. This department: 47.7%; UK: 30.4%.

- **Standard 4:** Serum lactate measured within one hour of arrival. This department: 67.7%; UK: 60.0%.

- **Standard 5:** Blood cultures obtained within one hour of arrival. This department: 50.5%; UK: 44.9%.

(Source: Royal College of Emergency Medicine)

We saw evidence senior ED leaders responded to these audit results. Actions were prioritised and reviewed regularly.

**Unplanned re-attendance rate within seven days**

We received up-to-date unplanned re-attendance rates within seven days following the inspection. The table below shows figures from October 2017 to September 2018:

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heartlands</td>
<td>4.62%</td>
<td>6.21%</td>
<td>5.56%</td>
<td>5.62%</td>
<td>6.47%</td>
<td>5.64%</td>
<td>6.42%</td>
<td>6.39%</td>
<td>6.15%</td>
<td>6.49%</td>
<td>6.04%</td>
<td>6.15%</td>
</tr>
</tbody>
</table>

From April 2018 to September 2018, unplanned re-attendance rate to A&E at BHH within seven days was worse than the national standard of 5% for each month. From April 2018 to September 2018, the unplanned re-attendance rate within seven days was 6.19% at BHH.

(Source: DR165)

We have not used figures for October 2017 to March 2018 to form a judgement as this was before the acquisition of Heart of England NHS Foundation Trust.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity, we have used this to form part of our judgement.

From August 2017 to July 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average.

**Unplanned re-attendance rate within seven days - University Hospitals Birmingham NHS Foundation Trust**
Please note: This includes attendances for April to June 2018, which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018, the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and generally better than the England average.

Unplanned re-attendance rate within seven days - Heart of England NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Competent staff

The service ensured staff were competent for their roles. Managers had conducted staff appraisals each year for most staff to provide support and monitor the effectiveness of the service.

Staff were required to have the necessary skills and competency for their role. Staff achieved this by conducting statutory and mandatory training with specialist training to support them in managing patients with a range of additional complex needs. A number of consultants sent out
weekly ‘topics of the week’ specialist training emails for all ED staff. Recent training had covered Parkinson’s Disease management.

Newly recruited staff were well supported particularly during their first 12 months in post. Leaders of the service welcomed new starters into the department and offered appropriate support. Senior paediatric ED staff wrote a welcome letter to all new starters in the department. This included contact details in case they needed to raise any concerns. Band six staff were in the process of setting up a mentoring programme for band five staff to ensure they received the necessary support. The mentor role included training and to ensure staff wellbeing.

Newly qualified nurses completed an induction and competency based training package covering all aspects of the ED. Nurses rotated through all areas of ED. The training progress of nurses was regularly reviewed and their allocated mentor would provide feedback and relevant support. The service provided effective training and development. The service had a training and development lead. New starters would have a four week supernumerary period followed by an 18 to 24 month development period. New starters attended study days specific to each area of the ED followed by a three month secondment into each ED area.

Leaders ensured staffing skill mix in the department was appropriate. ED had 25 Adult ED nurses trained to care for children. They had conducted a comprehensive training programme. This enabled these staff to fill unfilled shifts in the paediatric ED and when the escalation policy was instigated. We saw examples of when staff from the main ED had supported paediatrics ED with their staffing shortfalls.

Advanced care practitioners (ACPs) were used to fill shortfalls in the junior or middle-grade staffing rotas depending on experience. The role was competency based and there was a clear understanding of when escalation to a medic was required.

Appraisal rates
All medical staff had received an appraisal. However, not all nursing staff had received an appraisal as compliance was 63.2% compared to the 85% target.

Despite this, staff found appraisals useful and were a good opportunity to raise any concerns or identify any training they needed.

Birmingham Heartlands Hospital
From April 2017 to March 2018, 79.5% of required staff within the emergency department at Birmingham Heartlands Hospital received an appraisal compared to the trust target of 85%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>31</td>
<td>31</td>
<td>100.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>28</td>
<td>32</td>
<td>87.5%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>35</td>
<td>45</td>
<td>77.8%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>111</td>
<td>146</td>
<td>76.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>12</td>
<td>19</td>
<td>63.2%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

Multidisciplinary working
Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff at all levels communicated effectively for the benefit of providing patients with the most appropriate care and treatment. Nursing staff felt there was a good relationship with the consultants who were very supportive. We observed effective communication and positive interaction between ED staff and staff from other departments across the hospital and ambulance crew. Hospital staff and ambulance staff told us they had a well-established relationship. However, one paramedic reported their concerns around staff not always acknowledging ambulance crew.

Staff at BHH shared best practice with other ED sites across the trust. The introduction of the corridor nurse role at BHH was shared with the Queen Elizabeth Hospital (QEH) as an example of good practice. The QEH was also interested in implementing the emergency nurse practitioner role following its successful introduction at BHH. BHH ED was implementing NEWS2 in November 2018 to move in line with the QEH processes.

BHH ED staff had strong links with specialist services to best support vulnerable patients. The youth worker service co-ordinated with staff throughout the ED to provide support to vulnerable young people. Youth workers attended handovers to ensure there was a co-ordinated approach with the clinical teams to support young people. ED staff also worked closely with the Rapid Emergency Assessment and Communication Team (REACT). This team comprised experienced senior occupational therapists and occupational therapy technicians who understood and had access to locally available social and care support services.

In the paediatric ED, staff appropriately shared patient information. We saw in a patient’s notes where information had been shared regarding a patient who also received care from a local children’s hospital. Paediatric ED staff held meetings with a specialist children acute transport and advice service for the management of critically ill children requiring intensive care in the Midlands. This was to ensure they had a consistent approach to care and treatment they provided to children.

Seven-day services

The emergency department at Birmingham Heartlands Hospital provided care to the local community 24 hours a day, seven days a week.

Mental health support was provided to patients 24 hours a day. The RAID team were based on-site and generally review patient within 60 minutes. The Child and Adolescent Mental Health Services (CAMHS) attended children’s wards every day.

A dedicated youth worker team were on site from 7am to 9pm, Monday to Friday. The team ensured they followed up any referrals received out-of-hours on their return.

A clinical navigator was based in the minors department at Birmingham Heartlands Hospital from 7am to 7pm.

The GP service was based in ED minors from 10am to 10pm, seven days a week.

The paediatric ED was open 24 hours a day, seven days a week to provide care to children. Although, play specialists covered five days a week.

Health Promotion

There were limited health promotion materials available throughout the ED. However, we saw information boards advertising drug and alcohol support services. We did not see any healthy lifestyle promotions including smoking or obesity campaigns.

Although, the service had champions dedicated to mental health, dementia and learning disabilities. Frontline staff felt the support from the champions helped them provide specialist
support to patients with complex needs.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

We saw staff appropriately gained patient consent throughout our inspection before staff conducted any patient interactions. For example, in CDU we witnessed a consultant asked the patients permission before showing relatives their x-ray results. Staff in the paediatric ED were aware of the Gillick competence which is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Staff told us they saw a high number of patients with mental health concerns. On one of our inspection days, we saw there were three patients in ED requiring review from the RAID team. Staff told us this was a relatively low number compared to the number of mental health patients that normally attended ED.

Staff were knowledgeable about the Mental Capacity Act (MCA) and how to use it in practice. This was despite not all medical staff being up-to-date with mental capacity training. The trust combined safeguarding level 2, mental capacity and Deprivation of Liberty Safeguards (DoLS) training. Staff told us they would assume patients had capacity unless they had any capacity concerns when they would obtain consultant support.

The service had a clear process if patients needed to be detained under the Mental Health Act. Staff would complete an incident form if police attendance was required for a section 136. Section 136 is an emergency power which allows you to be taken to a place of safety from a public place, if a police officer considers that you are suffering from mental illness and in need of immediate care.

The ED had access to specialist mental health support. The Rapid Assessment, Interface and Discharge (RAID) mental health service for patients aged over 16. The team followed ED patient’s journey through rapid assessment, interface and discharge from start to finish. The team was available 24 hours a day, seven days a week at Birmingham Heartlands Hospital. Staff also had access to the trust’s psychiatric team for further support.

The service leaders were collaborating with partners to improve mental health support for patients. The executive root cause analysis meetings analysed incidents relating to patients with mental health needs and learned from incidents where patients had a poor experience.

ED had a clear process for managing patients detained under the Mental Health Act. Clinical site managers were responsible for accepting paperwork and ensuring patients were informed of their rights. Patient detentions were recorded on the incident recording database. The trust had a draft policy and procedural document for the use of the Mental Health Act due to be launched this year.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust combines safeguarding level 2, mental capacity and deprivation of liberty (DoLS) training.

**Birmingham Heartlands Hospital**

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to
March 2018 for qualified nursing staff in urgent and emergency care at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>43</td>
<td>43</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for this training module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in urgent and emergency care at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
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<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>19</td>
<td>29</td>
<td>65.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this training module.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Staff treated patients well and with kindness despite the busy and challenging ED environment.

Staff introduced themselves before any patient interactions. Staff were respectful and spoke to patients in a friendly way. Reception staff and the navigator were friendly and approachable. We spent 30 minutes at the reception desk in the minor’s area. Staff kept patients up-to-date about waiting times. Waiting times for minors and majors were displayed on a screen in the minors waiting area. However, during our inspection we noted the screen in the paediatric ED to display waiting times was not working. Despite this, parents told us staff kept them informed regarding the waiting times in the department.

Staff maintained patients’ dignity. We saw staff closed cubicle curtains when speaking with patients and conducting observations. Staff held confidential patient discussions away from public areas and in private rooms when available. Staff handovers were held away from the patient and public areas. Discussions between ED staff were appropriate. We saw a discussion regarding a patient with mental health and substance misuse concerns was held away from patient and public areas.

However, some ambulance crew told us the handover of patients in the corridor area did not always protect patient confidentiality, as there were often a number of patients present at the same time. We were also told staff sometimes shouted confidential patient information regarding their condition to one another down the corridor. However, we did not observe this during our
inspection. In addition, we saw there was a lack of privacy for registration in the reception area in the minors area. We saw senior staff were aware this was a concern as it was referenced in clinical governance meeting minutes. There had been discussions about adopting hoods in the reception area of minors to provide additional patient privacy.

Patients told us staff were caring without exception. A patient in the CDU told us the care had been “fantastic”. Their relative also confirmed they were pleased with the care their relative had received. Another patient described the care they had received as “exceptional” explaining that once they had checked in a nurse came to immediately change their dressing.

Senior staff shared the results of the departments’ friends and family test (FFT) performance with all ED staff. The FFT results for September 2018 for the paediatric ED were 79.31% would recommend the department and 16.26% would not recommend the department. Senior staff regularly reviewed the results to identify any themes. For example, in response to some negative feedback received, the department now had additional children’s activities.

Staff adapted their communication methods according to patient needs. In the paediatric ED, we saw staff used age appropriate language when speaking with children. When providing paediatric patients with information, advice and guidance, staff would maintain eye contact, by getting down to the patient’s level for face-to-face interactions.

Friends and Family test performance

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available.

The trust’s urgent and emergency care Friends and Family Test performance at BHH (% recommended) was worse than the England average from August 2017 to March 2018.

![A&E Friends and Family Test: Percentage Recommended](image)

England average response rate 12.70%
Heartlands response rate 10.20%

There was a deterioration in the BHH’s ED score from April 2018 (81%) to July 2018 (68%). The score increased to 72% in August 2018 however fell to 68% in September 2018.
We have included data from the pre-acquisition period, September 2017 to April 2018 only for contextual purposes and it did not form part of our judgement.

(Source: DR166)

The department had responded to FFT by actively requesting feedback throughout the department. We saw noticeboards displayed information on how to provide feedback about the care received.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

We saw a number of examples where staff alleviated patient anxieties. We observed a positive interaction between staff and a patient from abroad who appeared nervous and had informed the staff of their reservations. The member of staff showed empathy towards the patient, whilst reassuring the patient in a very caring manner, despite the language barrier. We saw patient feedback stored in the ED seminar room. Comments included “it was refreshing to see such an empathetic and patient focussed doctor.” Other comments regarding the paediatric ED stated: “We would like to say a huge thank you to staff; their care, courtesy and kindness in keeping us informed was deeply appreciated as we found this whole situation frightening.”

Staff appropriately assessed patient’s emotional wellbeing. We saw ED staff used the SAD persons scale. This is a scale to help assess patient’s mental wellbeing and are widely used for suicide risk assessments in clinical settings. ED shared the results with RAID who then further assessed any identified risks.

Staff worked to meet patients’ emotional needs. Patients had access to the trust’s bereavement service, chaplaincy service, patient’s advice and liaison service (PALS) and mental health and psychiatric services. Patients’ had access to a range of religious and spiritual leaders and resources available seven days a week.

Paediatric ED staff were knowledgeable about appropriately giving difficult news to parents and relatives. It was the responsibility of consultants in the paediatric ED for breaking bad news to parents and relatives. Dedicated family rooms were available to provide privacy to families. The paediatric ED had information to support parents experiencing the loss of their child. We saw the paediatric ED matron had produced a booklet called ‘saying goodbye to your child.’ This was sympathetically written and included useful information and contact details of child bereavement support services.

The trust and ED service supported staff to look after their own wellbeing. The trust offered staff resilience sessions and wellbeing events, which included self-help and bereavement, for example. Senior staff supported staff with their emotional wellbeing. Staff provided examples of when the ED matron had supported them when they were experiencing personal difficulties.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

Staff supported patients to be actively involved in decisions about their care and treatment. We saw staff provided patients with detailed explanations in a way patients could easily understand. Staff gave patients and relatives time to ask any questions about any concerns they had. We saw where staff had taken a patient for an x-ray and they explained all parts of the process and what to expect next. The patient thanked staff for this.

Patients scored the trust similar to the national average. The trust scored about the same as
other trusts for 23 of the 24 Emergency Department Survey questions relevant to the caring domain.

**Emergency Department Survey 2016**

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Patients scored the trust’s performance similar to the national average in the Emergency Department Survey 2016. The trust scored about the same as other trusts for 23 of the 24 Emergency Department Survey questions relevant to the caring domain. The score for the remaining question was suppressed due to low figures.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>No score</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

ED staff provided services in a way that met the needs of local people. Staff at all levels were involved with planning the service and implementing changes.

We saw ED had two private rooms for bereaved relatives and for holding confidential or sensitive discussions.

The adult ED had two separate waiting areas for the majors and minors areas of the department. Both areas had adequate seating with a separate reception area.

The children’s emergency paediatric department was spacious with a reception area, waiting area and a children’s area with toys available. The department had 10 cubicles. The department was segregated from the main emergency department by lockable doors, which were only accessed by authorised staff using a swipe card system. Paediatric ED could be accessed by the public from a separate entrance leading in from outside the hospital. This meant children did not have to walk through the adults ED area to gain access to the department; particularly if there were aggressive or violent patients.

The paediatric department had a child friendly poster on entry to the department displaying photographs of staff who worked in the department.

Specialist support services supported vulnerable patients. The youth worker team remit was to also assist homeless patients. The service was adapted to meet the needs of the local community.

**Meeting people’s individual needs**
The service considered patients’ individual needs when delivering and coordinating services in the ED.

The ED at Birmingham Heartlands Hospital served a broad range of ethnic groups and nationalities reflecting the current East Birmingham population accessing the service. The ED provided a wide range of information leaflets and guidance on the walls of the ED describing the function and pathway of each part of the ED service. However, this was only available in English. Staff told us ED staff were ethnically diverse and staff would often be used to translate for patients and relatives whose first language was not English. This is not in accordance with best practice. Some staff told us they could print out leaflets in other languages from the trust’s website. However, when we asked them to do this they were unable to.

In the paediatric ED, staff used different methods of communication appropriate to the patient’s needs. Staff used communication cards to help communicate with children with learning disabilities. For example, there were images of medical procedures such as an injection. Staff used British Sign Language to communicate with children with hearing loss. The paediatric ED had two play specialists on site five days per week from 10am to 10.30pm. The service planned to extend this cover to seven days a week.

Records evidenced staff held person-centred discussions with patients and individualised care pathways where appropriate. Elderly care nurses visited ED every morning from 8am to 9am to try to avoid admissions. Older patients attending ED could go to the day centre on Ward 21 where an elderly care consultant assessed physical needs and care provided in the community.

The emergency department had a dedicated clinical decisions unit. This was a consultant-led observational medicine area for patients awaiting investigation or treatment that would take less than 24 hours.

Staff prioritised patients with complex needs. We saw staff ensured patients with dementia and learning disabilities were moved to a cubicle as soon as possible to limit any distress. The handover sheet the corridor nurses completed when receiving patients arriving by ambulance included a section on learning disabilities and dementia for staff to complete. A health care assistant had produced a dedicated dementia trolley, which was based in the clinical decisions unit. This included twiddle blankets and mittens which staff had helped knit. There were also old photos, dolls, puzzles, mood lights and a day and night clock. Staff used this equipment to help distract patients, give them some activity while waiting, stimulate and reduce anxiety and agitation. This equipment was also suitable for patients with learning disabilities and for distraction therapy.

ED staff supported patients with learning disabilities. A learning disability webpage was available on the trust’s intranet for staff to access the learning disability acute liaison nurse teams service for support. During our inspection, we observed staff made reasonable adjustments for a patient with learning disabilities by accompanying them for their x-ray. Staff reassured the patient, and explained what they were doing to ensure the patient and their carer understood.

Emergency Department Survey 2016

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust scored better than other trusts for one of the three Emergency Department Survey questions relevant to the responsive domain. The trust scored about the same as other trusts for the remaining two questions.
<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.5</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Access and flow**

Patient care was not always managed well to take into account the needs of patients requiring urgent care. The trust mostly did not meet the four hour target for patients to be admitted, transferred or discharged within four hours of arrival into ED from April 2018 to September 2018.

A clinical navigator was based in the reception area of the minors department of ED at Birmingham Heartlands Hospital. The clinical navigator was usually a band six and reviewed all ambulant patients arriving into minors. They used a navigation tool to triage patients to ensure they were signposted to a suitable clinical area for their clinical needs. Staff felt the role of the navigator was positive for directing patients to the appropriate care pathway. The GP reported that they only admitted approximately seven percent of patients they had assessed.

The ED at Birmingham Heartlands Hospital used an electronic system to monitor and analyse the flow of patients through the department and the hospital as a whole. The ED had three flow coordinators who were responsible for determining where there were delays in other parts of the hospital for ED patients to be transferred to. They also followed up four hour breaches, scans and X-ray reports. The staff explained they help with patient flow, to free up staff by chasing the administration pathway for patients.

The flow coordinators liaised closely with the site office and bed managers. Staff felt this role was an effective addition to ED which took the pressure of monitoring bed capacity off clinical staff. The increased ENP coverage across ED gave minors and paediatrics more flow. Staff felt patient safety had improved due to the better flow however further improvements with flow were required.

The GP service was based in ED minors from 10am to 10pm, seven days a week. This helped improve the flow of patients by seeing 24 percent of patients arriving in minors.

We saw and staff told us patients were pushed from ED into other areas of the hospital rather than pulled through which could result in inappropriate transfers of patients. ED staff felt like the challenges ED experienced with patient flow was seen as an ED problem and other areas of the hospital did not have a proactive approach to help relieve this.

Patients’ response regarding their waiting times in the department were mixed. Some patients felt they had been seen reasonably quickly, others described waiting a while. However, patients did acknowledge how busy the ED was. In the minors area, a screen informed patients and relatives how long the average wait was in minors, majors and paediatrics. There was a screen for this in the paediatrics department; however, it was not in use. Staff stated it had been broken for a few weeks.

The ED maintained a negative comments folder. We saw feedback from 2 June 2018 about the
time a patient had to wait “due to Heartlands Hospital being short staffed, I had to wait for 6 hours in A and E”. However, the feedback went on to say that, “this is not the fault of the staff or the quality of their work as I know they are working as quickly and efficiently as possible.”

Relatives in paediatrics ED told us they were kept up-to-date about waiting times. However, we observed some patients asking staff about waiting times in the paediatrics department and staff stated that they could not give a time.

**Median time from arrival to treatment (all patients) at BHH:**
From April 2018 to September 2018, the median time from arrival to treatment (minutes) was 74 minutes.
(Source: DR167)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity, we have used this to form part of our judgement.

The trust submitted two separate sets of figures from April to July 2018, one for Queen Elizabeth Hospital and a combined figure for the other trust sites.

Queen Elizabeth Hospital did not meet the standard over the 12-month period from July 2017 to June 2018. The trust also performed worse than the England average across the entire reporting period.

In April 2018, the other sites met the standard and had a median time lower than the England average by two minutes. From May 2018, onwards these sites reported times higher than both the standard and the national average.

The trust has submitted the below figures for the median time from arrival to treatment for August 2017 to July 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>University Hospitals Birmingham NHS Foundation Trust</th>
<th>Former Heart of England NHS Foundation Trust sites</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>65</td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>Sep-17</td>
<td>73</td>
<td></td>
<td>58</td>
</tr>
<tr>
<td>Oct-17</td>
<td>78</td>
<td></td>
<td>59</td>
</tr>
<tr>
<td>Nov-17</td>
<td>81</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Dec-17</td>
<td>63</td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>Jan-18</td>
<td>84</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>Feb-18</td>
<td>85</td>
<td></td>
<td>61</td>
</tr>
<tr>
<td>Mar-18</td>
<td>85</td>
<td></td>
<td>64</td>
</tr>
<tr>
<td>Apr-18</td>
<td>76</td>
<td>58</td>
<td>60</td>
</tr>
<tr>
<td>May-18</td>
<td>72</td>
<td>68</td>
<td>61</td>
</tr>
<tr>
<td>Jun-18</td>
<td>76</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>Jul-18</td>
<td>90</td>
<td>73</td>
<td>64</td>
</tr>
</tbody>
</table>

Data from April 2018 was still being submitted using the trust code for Heart of England NHS
Foundation Trust up to (and including) July 2018.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In August 2017, the trust performed better than the standard but above the England average. However, from September 2017 to March 2018 the trusts performance was stable at a level above both the standard and England average.

(Source: NHS Digital - A&E quality indicators)

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

From April 2018 to September 2018, the percentage of patients waiting more than four hours from the decision to admit until being admitted was 6.06%. This was just below the national standard of 95% as 93.94% of patients were admitted, transferred, or discharged within four hours of arrival in the emergency department.

(Source: DR169)

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity, we have used this to form part of our judgement.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018, the trust failed to meet the standard and performed worse than the England average in every month, other than in December 2017 when trust performance exceeded the average.

Four hour target performance - University Hospitals Birmingham NHS Foundation Trust
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018, the trust failed to meet the standard and performed worse than the England average.

Four hour target performance - Heart of England NHS Foundation Trust

(Source: NHS England - A&E waiting times)

Data received from the trust following the inspection showed from April 2018 to September 2018, 79.02% of patients were admitted, transferred, or discharged within four hours at Birmingham Heartlands Hospital. This was below the Department of Health’s target of 95%. (Source: DR168)
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018, the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Heart of England NHS Foundation Trust

The following table shows the monthly number of patients waiting more than four hours to admission:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>1,218</td>
</tr>
<tr>
<td>Sep-17</td>
<td>1,374</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1,500</td>
</tr>
<tr>
<td>Nov-17</td>
<td>1,483</td>
</tr>
<tr>
<td>Dec-17</td>
<td>2,089</td>
</tr>
<tr>
<td>Jan-18</td>
<td>2,453</td>
</tr>
<tr>
<td>Feb-18</td>
<td>2,339</td>
</tr>
<tr>
<td>Mar-18</td>
<td>2,363</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E SitReps).

Number of patients waiting more than 12 hours from the decision to admit until being admitted

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS
Foundation Trust in this analysis. Because it related to the same legal entity, we have used this to form part of our judgement.

Over the 12 months from August 2017 to July 2018, two patients waited more than 12 hours from the decision to admit until being admitted. These occurred in August 2017 and May 2018 with one patient waiting more than 12 hours in both months.

Heart of England NHS Foundation Trust
From April 2018 to September 2018, there were no patients waiting more than 12 hours from the decision to admit until being admitted at BHH.

(Source: DR171)

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From September 2017 to August 2018, one patient waited more than 12 hours from the decision to admit until being admitted. This occurred in February 2017.

(Source: NHS England - A&E waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

University Hospitals Birmingham NHS Foundation Trust
We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity, we have used this to form part of our judgement.

From August 2017 to July 2018, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was worse than to the England average, with null returns from the trust in April – July 2018.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - University Hospitals Birmingham NHS Foundation Trust
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In August 2017 and September 2017, the monthly percentages of patients that left the trust’s urgent and emergency care services before being seen for treatment were worse than the England average, with the rate falling to just below the England average in October 2017.

From November 2017 to March 2018, the trust submitted zero returns, which may indicate a data collection issue.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - Heart of England NHS Foundation Trust**

(Source: NHS Digital - A&E quality indicators)

**Median total time in A&E per patient (all patients)**

Heart of England NHS Foundation Trust

From April 2018 to September 2018, the median total time in A&E per patient was 171 minutes. (Source: DR170)

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018, the trust’s monthly median total time in A&E for all patients was higher than the England average.

**Median total time in A&E per patient - Heart of England NHS Foundation Trust**
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Staff told us they were proactive in dealing with complaints as soon as possible. This was in an attempt to deescalate and alleviate concerns and prevent formal complaints. We discussed complaints with staff during the inspection. The paediatric ED had one open complaint, which senior staff were in the process of investigating. Paediatric senior staff held paediatric meetings with senior staff at Good Hope Hospital where complaint themes were shared. Complaints were discussed at staff meetings and learning shared.

Information was shared with patients and relatives to provide feedback about the service. Patient Advice and Liaison Service details were displayed on noticeboards across the department.

Summary of complaints

From April 2017 to March 2018, there were 179 complaints about urgent and emergency care services across the trust as a whole. The trust took an average of 38 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be resolved within 30 working days.

Of the 14 complaints still open at the time of reporting, all had been open longer than the trust target of 30 working days, the longest being open for 236 working days.

A breakdown by site is below:

- Birmingham Heartlands Hospital: There were 43 complaints, the main themes were all aspects of clinical treatment with 24 complaints (55.4%), attitude of staff with eight complaints (18.6%) and admissions, discharge and transfer arrangements with five complaints (12.1%)

- Unspecified location: Three complaints did not have the hospital site specified, two of these related to all aspects of medical care and one related to ‘Other’.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Thank you cards and compliments from patients expressed patient and relatives gratitude for information staff provided during upsetting circumstances. Parents confirmed they were provided with sufficient information once their child was discharged from the paediatric ED.

**Number of compliments made to the trust**

From April 2017 to March 2018, there were 148 compliments within urgent and emergency care.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>98</td>
<td>66.2%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>24</td>
<td>16.2%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>17</td>
<td>11.5%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>9</td>
<td>6.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>148</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

A clinical service lead and a group manager led the emergency department directorate for Birmingham Heartlands Hospital. ED was part of the HGS division 3, group A, led by a divisional director. A matron led the daily running of the ED along with senior sisters. Staff told us service leaders were visible and approachable. A number of staff members told us how supportive the matron was in supporting staff in the extremely busy and pressurised ED environment. One staff member gave us an example of when the matron had supported them when they were experiencing personal difficulties outside of work.

The department had a ‘flat’ structure rather than a hierarchical departmental structure. Staff felt able to challenge one another and raise concerns, which senior staff dealt with in a timely way.

Staff told us overall it had been business as normal since the acquisition. The biggest change was the shift in the divisional structure of the ED teams but felt this had been a smooth change and encouraged cross-site working.

**Vision and strategy**

The ED service at Birmingham Heartlands Hospital had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The new trust vision and strategy was not yet fully integrated into the ED at BHH. This was despite the trust values being displayed throughout the ED. Most staff we spoke with could not say what these values were when asked. However, one consultant described the trust values in detail. Since the trust had acquired the Heart of England NHS Foundation Trust, the trust had produced a renewed vision ‘to build healthier lives.’ Despite this, staff demonstrated providing the best patient care possible remained their priority, which we saw in practice.
Following the acquisition of Heart of England NHS Foundation Trust a new strategy for the expanded trust is in development moving from "Delivering the Best in Care" to the trust's renewed vision of "Building Healthier Lives". The ED senior staff worked within the wider health and care system and with other public services and commissioners to promote health and wellbeing. This was coordinated as Birmingham and Solihull Sustainability and Transformation Partnership in which the trust was involved.

Senior ED staff regularly met with external agencies to plan their strategy in line with the local community. This included meeting with police to discuss violence, frequent users and the frequent attender CQUIN. Action plans were produced to ensure each agency was aware of what changes and improvements they were responsible for.

**Culture**

**Managers across the ED promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.** Staff at all levels felt part of the ED team.

Staff were resilient, passionate and committed to providing high levels of patient care despite the busy and challenging ED environment. The department had a number of long-standing staff and some staff who had previously left the trust had returned to work in ED due to the strong team approach. Staff were proud of the high levels of patient care they provided. One long-standing member of staff told us “the excellence of the team is what keeps us here.” “Everyone is really dedicated to the task of safe care even at times of maximum pressure.” Numerous staff told us the department was like “one big family” and staff supported one another in a busy and challenging ED environment. Another staff member told us: “the department works because the team works.”

We saw the morale of staff in ED was high. Senior staff were proactive in thanking their staff for their hard work to recognise their efforts. However, some paediatric ED staff felt morale had been affected due to the staffing challenges the department was currently experiencing.

Staff at all levels felt confident to challenge one another without fear of retribution. Staff were responsive to one another and overall there was a mutual respect seen. Staff felt empowered to make suggestions about making changes in ED and conducting audits etc. During the medical handover, we saw arrangements made for a trainee doctor to watch an Advanced Clinical Practitioner perform a procedure as a training exercise. However, some porters felt communication with doctors and some nurses was sometimes not appropriate, as some staff would talk down to them, which they had escalated to their supervisors. Despite this, they told us “it is a nice place to work, and we interact well with patients.”

Staff at the ED sites coordinated to support each other. Senior staff from Good Hope Hospital were supporting Birmingham Heartlands Hospital staff to improve some areas of the ED. This was as they had experienced similar concerns themselves and could share learning. Staff told us it was like there was shared ownership of concerns across sites.

Numerous staff told us they would recommend the ED to close family and friends. Some staff gave examples of where their family had received good care in the department.

Staff were aware of the Duty of Candour regulation. The Duty of Candour requires health service bodies to act in an open and transparent manner when things go wrong. We asked five members of staff about the Duty of Candour. All staff could describe this as being open and honest with patients and relatives. They told us they would inform patients and family and their line manager if they had made a mistake. Senior staff preferred to try and meet with relative as soon as possible.
as this was more personal than just sending a letter notifying relatives a mistake was made. From April 2017 to March 2018, the trust had applied Duty of Candour 76 times in ED. This was not broken down to site level.

**Governance**

The service used a systematic approach to continually improving the quality of the emergency department at Birmingham Heartlands Hospital.

The service had a clear governance structure and staff understood their roles and who they were accountable to. The emergency department monitored risk management and governance systems to ensure patient outcomes were appropriate. This information was shared at team meetings, staff handovers and through ED newsletters.

Senior staff attended emergency department meetings each month. They ensured key messages were shared to each level of staff in the department.

We reviewed the minutes of the last three emergency clinical governance meeting minutes for March 2018, May 2018 and July 2018. They documented that senior staff discussed the main ED themes and learning from incidents and complaints and shared.

The ED held mortality and morbidity meetings to reviewed patient deaths and whether patient care in ED had been appropriate. All grades of staff from a variety of disciplines attended the meetings to ensure multidisciplinary discussions took place. Senior staff shared learning, required actions from case reviews at staff handovers, team meetings, emails, and included in staff safety bulletins.

**Management of risk, issues and performance**

Senior ED staff understood the local risks to the service. However, the service did not evidence they regularly reviewed and monitored all current risks. The service had not acted in a timely way to improve medical and nursing staffing levels in the department.

Leaders of the service were in agreement about what were the main risks to the BHH ED service. Senior staff indicated overcrowding, middle-grade medical staffing and patient safety were top of their worry list. Local risks were added to the divisional and local risk register. The ED team felt there was shared ownership of the risks in ED rather than just an ED problem. However, we did not see evidence the four hour target performance was regularly monitored and discussed. Service leaders did not demonstrate oversight of fully meeting the needs of the local population. We saw patient information was not easily accessible in other languages. This was not included as a risk on the department's risk profile.

The risk registers for the department were maintained at a divisional and executive level. The quarterly compliance and assurance report to the board highlighted any concerns. Senior leaders escalated strategic risks to the Board Assurance Framework (BAF) report which was presented to the board every quarter. Overall compliance with the process was outlined in the trust’s risk management policy.

During the inspection, we saw at a local site level the service leaders had oversight of some of the risks to the service and managed them well. The corporate risk profile for October 2018 showed four risks specific to either Birmingham Heartlands Hospital emergency department or trust wide urgent and emergency care. However, this risk profile did not include any actions or mitigations or dates when each risk had been reviewed. We had concerns the service would therefore not be able to monitor the progress and ownership of improvements and mitigations put in place.
We reviewed minutes from emergency department clinical governance meetings for March 2018, May 2018 and July 2018. These minutes recorded senior leaders had discussed the main risks to the service on their risk register; staffing, skill mix, overcrowding and assessment of mental health patients and access and flow. During this inspection, we identified the consultant cover was not in line with national guidance, this was not included as a risk on the risk profile. However, the clinical governance minutes indicated this had been discussed. Leaders of the service were aware of this risk and were planning to mitigate this risk with further medical recruitment.

The service planned for emergencies and staff understood their roles if one should happen. The hospital had a major incident plan. The service had recently reviewed its major incident plan, which was available to staff on the trust’s intranet. Staff conducted major incident training during their induction with decontamination updates completed every two years.

The service had processes in place for the recognition and management of sepsis. This was in accordance with the National Institute for Health and Care Excellence Guideline NG51 Sepsis: recognition, diagnosis and early management.

**Managing Information**

The trust did not always collect, analyse, manage and use information well to support all its activities.

Staff did not always use security safeguards to ensure patient information remained confidential. We saw on a number of occasions in the major’s area of ED where staff had not locked computers when they were not in use to prevent unauthorised people from accessing confidential patient information.

Staff could not easily share all information with staff from other parts of the trust. However, the trust’s IT department was in the process of merging the current IT systems across all sites to allow the trust to have one integrated IT system. This would allow ED staff at BHH to share and transfer information to other sites more easily.
Staff told us ineffective and access to IT equipment slowed down the flow of patients through ED. For example, the blood test results system was time consuming to complete especially as printers were regularly out of order.

Staff told us access to computers in ED was a problem when the department was very busy. We were provided with examples of when staff had to queue to use a computer, which further affected patient flow.

We requested a large amount of data from the trust post inspection to assist us to make judgements about the ED at BHH. However, the majority of data was not split by hospital site as requested or was in a format that was difficult to analyse and understand. We were not assured the trust’s data management systems supported senior staff to have oversight of their services at individual ED site levels.

**Engagement**

ED staff engaged and collaborated effectively with patients, the public and local and partner organisations to plan and manage an appropriate ED service.

The ED participated in a number of trust and community engagement events. For example, the new trust’s annual ‘Building Healthier Lives Awards.’ This allowed staff, patients and relatives to recognise staff who had gone beyond what was expected in their role. The BHH attended a patient focus group and as a result, patients had visited the department to see what the team do.

The ED had an ED newsletter, which included ‘Star of the Newsletter’. We saw in September 2018’s edition a health care assistant had been nominated for their work with dementia patients. They were also commended for developing the dementia trolley and arranging for the ED to have adapted cups, plates and cutlery.

The trust held quarterly emergency department meetings at Birmingham Heartlands Hospital. All ED staff were invited. Information from these meetings was shared with staff email at handovers and by email.

We saw trust posters displayed across the department providing patients and relatives with information to share feedback.

The service engaged with local community services. A consultant had links with a youth offending service and tried to recruit them into the trust. The ED had links with the local police service as part of a violence prevention alliance.

ED have favourable event reporting form to commend staff and good practice. Staff let the educational supervisor if this applied to a trainee.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The department had a strong educational ethos. The clinical lead had developed and integrated Heartlands Elderly Care, Trauma & Ongoing Recovery (HECTOR) project into the elderly patient clinical pathway. This changed the ED approach to triage and imaging, the length of stay reduced from 22 days to 16.5 days and complications were reduced. The HECTOR team set up a training course, which was also launched at other trusts in the UK and abroad. The team won the Central Research Network award, NHS 70 Parliamentary award and were nominated for a trust ‘Building Healthier Lives Award’, 2018 for this project.
Senior leaders told us they in the early stages of proposing a newly purpose build emergency department. The trust was currently building a new ambulatory care and diagnostics centre due for completion in 2020. Once this building was completed, ED staff hoped the new ED would be the next new build project at BHH.

Staff were updated with updates regarding the ED. Information relating to the department was shared on staff noticeboards.

Clinical updates were shared with staff in a variety of different media. ACPs and consultants conducted podcasts covering a variety of clinical conditions pertinent to ED.

ED at BHH worked closely with other stakeholders in the region to review and monitor capacity taking into consideration winter pressures and the increase of activity. The ED had an agreement with a local ambulance trust to provide two hospital ambulance liaison officers (HALO) situated in the main ED to assist with patient flow. HALOs covered two shifts patterns from 7am to 7pm and 2pm to 2am to cover peak activity in the department. ED staff and ambulance crew we spoke with told us the HALO role was a useful addition to the department. However, HALOs felt frustrated with the lack of available trolleys and patient flow through ED.

Birmingham Heartlands Hospital ED was the first trauma unit in the country to have the dedicated youth worker team on site. Senior staff told us this was a great achievement and staff had worked hard to ensure this was implemented and the service was already well integrated into the ED.

Staff told us they had recently submitted a business plan to extend the clinical areas into the waiting area for the majors department to improve patient flow.
Medical care (including older people’s care)

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

The medical care service at University Hospital Birmingham NHS Foundation Trust provides care and treatment for a wide range of specialties including:

- cardiology
- colorectal
- diabetes
- endoscopy
- infectious diseases
- neurology
- oncology
- renal
- respiratory
- stroke

There are 1,579 medical inpatient beds located across 56 wards plus 17 beds on a multi-specialty ward for private patients at Queen Elizabeth hospital.

The trust also provides acute medical care at Birmingham Chest Clinic, Castle Vale Renal Dialysis Centre and Runcorn Road Renal Dialysis Centre.

(Source: Routine Provider Information Request (RPIR) – Sites – All tab)

At Queen Elizabeth Hospital acute medicine is delivered through a 74-bedded consultant-led clinical decision unit which accepts referrals from the emergency department and the single point of access unit. The unit has a four-bedded level two facility catering for patients with multiple organ failure. The ambulatory medical clinic is open 24 hours a day, seven days a week and manages approximately 7,000 patients per year.

(Source: Acute Provider Information Request (RPIR) – Context acute QE tab)

Specialist elderly care services operate across the Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital sites with a frailty ambulatory emergency care available on the medical day units (MDU) at both Birmingham Heartlands Hospital and Good Hope Hospital. Teams are multi-professional and assess patients in the emergency department who are suitable to be managed in the MDU as an ambulatory patient. The team also carry out comprehensive geriatric assessments, instigate and carry out appropriate diagnostics and interventions with the
aim to return the patient to their usual place of residence with or without support services. At Solihull Hospital ambulatory care is provided via the frailty advice and support team who operate out of the medical day unit.

Additionally, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital provide ortho-geriatric support to the trauma and orthopaedic wards and all geriatricians run afternoon outpatient clinics.

There is also a well-established dementia and delirium team which works across all of the complex elderly care wards at all three sites and aims to educate staff, patients and carers on dementia and delirium care.

(Source: Acute Provider Information Request (RPIR) – Context acute HGS tab)

At the Birmingham Heartlands Hospital location, medical care is provided on 16 wards which accounts for 462 beds.

A site breakdown can be found below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>Rowan ward</td>
<td>Gastroenterology</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Ward 2</td>
<td>General medicine</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Ward 3</td>
<td>Renal</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Ward 6</td>
<td>Cardiology</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 7</td>
<td>Short stay acute medicine</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Ward 19</td>
<td>Oncology</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Ward 20 acute medical unit 1</td>
<td>-</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Ward 21</td>
<td>Elderly care</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Ward 22 acute medical unit 2</td>
<td>-</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Ward 23 acute stroke unit</td>
<td>Stroke</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Ward 23 HASU</td>
<td>Stroke</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Ward 24</td>
<td>Respiratory</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Ward 26</td>
<td>Cystic fibrosis unit</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Ward 28</td>
<td>Infectious diseases and tropical medicine</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Ward 29</td>
<td>Diabetes</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Ward 30</td>
<td>Elderly care</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td><strong>Total beds</strong></td>
<td><strong>462</strong></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites – All tab)

During our inspection we visited the endoscopy department, discharge lounge, frailty assessment unit (Ward 21), frailty short stay assessment unit, elderly care (Ward 29 and 30), general medicine (Ward 2), respiratory ward (Ward 24), cystic fibrosis unit (Ward 26) acute/hyper acute stroke ward (Ward 23), acute medicine unit (Ward 22), renal medicine (Ward 3), oncology ward (Ward 19), cardiology ward (Ward 6) and infectious disease and tropical medicine ward (Ward 28).

We spoke with 52 staff including nursing staff of all levels, medical staff of all grades, non-registered staff and allied health professions. We also spoke with 15 patients and six relatives. As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of patients who could not speak with us. We observed interactions between staff, patients, and patient’s relatives,
considered the environment and looked at 23 medical and nursing care records and 15 patient observation / sepsis screening pathways.
Is the service safe?

Mandatory training

Mandatory training completion rates

Birmingham Heartlands Hospital

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>501</td>
<td>503</td>
<td>99.6%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Medicines management</td>
<td>498</td>
<td>500</td>
<td>99.6%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>500</td>
<td>503</td>
<td>99.4%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>480</td>
<td>501</td>
<td>95.8%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Waste management</td>
<td>462</td>
<td>503</td>
<td>91.8%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>446</td>
<td>491</td>
<td>90.8%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>452</td>
<td>503</td>
<td>89.9%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>444</td>
<td>503</td>
<td>88.3%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>438</td>
<td>499</td>
<td>87.8%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>438</td>
<td>503</td>
<td>87.1%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Information governance</td>
<td>423</td>
<td>503</td>
<td>84.1%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>409</td>
<td>497</td>
<td>82.3%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall training compliance rate of 91.4% for qualified nursing staff. The trust’s 90% completion target was met for six of the 12 mandatory training modules for which qualified nursing staff were eligible. The resuscitation - clinical module had the lowest completion rate, at 82.3%.
A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in medicine at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>218</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>211</td>
</tr>
<tr>
<td>Medicines management</td>
<td>211</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>192</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>178</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>151</td>
</tr>
<tr>
<td>Information governance</td>
<td>145</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>144</td>
</tr>
<tr>
<td>Fire safety</td>
<td>143</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>129</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>122</td>
</tr>
<tr>
<td>Waste management</td>
<td>103</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall training compliance rate of 74.2% for medical staff. The trust’s 90% completion target was met for three of the 12 mandatory training modules for which medical staff were eligible. The waste management module had the lowest completion rate, at 47.0%.

Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff through mandatory training. Mandatory training subjects included for example, fire safety, moving and handling, basic life support, safeguarding vulnerable adults and safeguarding children. Mandatory training was delivered face-to-face and through an online learning management system.

Staff told us they were in the process of attending an acute illness management course. The ward manager on ward 20 and ward 3 told us all staff had been allocated a date for attending the course. The training included identifying and managing patients with sepsis. Sepsis is a severe infection, which spreads in the bloodstream. Training included the use of sepsis screening tools and use of sepsis care bundles.

The trust sepsis clinical guideline and the sepsis screening tools were updated in line with the National Institute for Health and Care Excellence (NICE) NG51 guideline.

Staff had the skills, knowledge and experience to identify and manage issues arising from patients’ mental health conditions, learning disability, autism and dementia. All staff received training as part of their mandatory training. Junior doctors had specific training in managing delirium (acute confusion) and medical staff, who did psychiatry as part of their rotation, had training in managing depression and psychosis.
Safeguarding

Safeguarding training completion rates

Birmingham Heartlands Hospital

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>502</td>
<td>502</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ deprivation of liberty safeguards and mental capacity</td>
<td>486</td>
<td>495</td>
<td>98.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall safeguarding training compliance rate of 99.1% for qualified nursing staff. The trust's 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in medicine at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>197</td>
<td>218</td>
<td>90.4%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ deprivation of liberty safeguards and mental capacity</td>
<td>169</td>
<td>218</td>
<td>77.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall safeguarding training compliance rate of 83.9% for medical staff. The trust's 90% completion target was met for one of the two safeguarding training modules for which medical staff were eligible.

There were up-to-date safeguarding policies and procedures in place, which were accessible to staff through the trust's intranet site. Staff demonstrated a good understanding of the safeguarding policies, procedures and what to do should a safeguarding situation arise. Staff were able to tell us of examples where they had raised a safeguarding concern with the trust team who took it forward. Staff were aware of how to contact the safeguarding team during working hours if they required help and advice. We also saw members of the safeguarding team visiting ward areas during our inspection.
Staff had a general awareness of female genital mutilation (FGM) and the requirements to raise this with the local safeguarding team. FGM is defined as the partial or total removal of the female external genitalia for non-medical reasons. FGM was not currently included in the safeguarding training which was mandatory for all staff, however there was a separate electronic learning module which staff could access.

During our inspection, we visited Ward 26 (Cystic Fibrosis Unit). The ward had recently reinstated the transitional care pathway for 16 to 18-year-old patients with this condition, however senior staff told us no staff members had not undergone safeguarding children level three training. They were however aware of the risk of having young people of this age and had a general awareness of the increased risks which this age group face. Staff were able to tell us of an example where they used their current safeguarding knowledge to escalate a concern about a young person who kept disappearing from the ward area without staff awareness of where they were going. This had prompted the ward staff to reconsider procedures on the ward to ensure they managed this patient group safely.

Staff told us they had patients admitted to their wards with suicidal intentions or a history of self-harm. For these patients, their main source of support for the management of the patient was from the mental health team (RAID - rapid, assessment, interface and discharge team). All staff were required to complete basic mental health training which was provided by the trust safeguarding team, however all staff acknowledged they relied on the quick intervention of the RAID team. Patients who required urgent assessment by the mental health RAID team were seen within one hour of referral. All staff told us the team were extremely responsive to their referrals.

Cleanliness, infection control and hygiene

Most of the wards we visited were visibly clean and tidy, although some wards we observed some clutter from equipment and stores in the ward areas. We observed alcohol hand gel near the entrance for staff, patients and visitors to use, as well as alcohol hand gel being available at point of care. We observed good hand hygiene during our visits to the ward, with staff adhering to the five moments for hand hygiene (World Health Organisation). These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients. We did however observe some members of staff not completely adhering to the bare below elbow policy whilst providing personal care.

All ward areas had access to personal protective equipment (PPE) and we observed staff wearing PPE appropriately. We also observed additional PPE that was available for staff to use when caring for infectious patients, for example, on Ward 24 we saw masks available for staff and on Ward 28, they had masks, hoods and suits used for highly infectious patients.

Information provided by the trust showed from April 2018 to September 2018 there were nine *Clostridium difficile* (*C. difficile*) infections, one trust apportioned MRSA bacteraemia, five Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia and 15 *Escherichia coli* (*E. coli*) bacteraemia infections. This information involved all medical wards and departments across Birmingham Heartlands, Solihull and Good Hope Hospital.

All wards used the ‘I am clean’ system to identify when items of equipment were clean and ready for reuse. However, we did observe some equipment which was not clean. On Ward 24 we observed some items on the resuscitation trolley which had a layer of dust on them as well as a commode which had old (dried) body fluids on this. We also observed resuscitation equipment which was dusty on the acute medical unit (AMU) and observation machines with used
thermometer ear probe covers left on them. We reviewed 38 items of equipment; we saw the use of 'I am clean' stickers on 32 of these items of equipment. Therefore, we were mostly assured equipment had been cleaned before patient use.

There was an infectious diseases and tropical medicine ward (Ward 28) within the hospital. The ward had 23 single rooms to house patients with transmissible infections, six of them were negative pressure single rooms (type of ventilation system used to prevent air flowing from room to room) where patients with more contagious infections such as multi-drug resistant and extremely drug resistant tuberculosis were allocated. Staff working on these wards had more in-depth knowledge and skills caring for patients with contagious infections which could be shared with staff from other wards if required.

All patients received an infection prevention and control risk assessment on admission into hospital. This was part of the admission documentation and requested the healthcare professional to review the patient's previous history so correct bed allocation could be achieved on the ward. Known infection prevention and control risk patients were allocated a single room to prevent the risk of transmission to other patients (source isolated) and in most cases (10 out of 11 isolated patients), the door to the single room was closed. We did however observe one patient who was located in a single room due to infection risks with the door open and no risk assessment completed to support why the door needed to be left open.

Ward 19 had seven positive pressure ventilated lobby (PPVL) rooms. These rooms were suitable for preventing the spread of pathogens transmitted by the airborne route. A reading gauge was available showing the pressure in the lobby with respect to the corridor and was mounted at eye level on the corridor wall adjacent to the lobby entry door. This was in accordance with Health Building Note 04-01 Supplement 1-Isolation facilities for infectious patients in acute settings. Pressure monitoring of these rooms was in accordance with trust policy and was evident outside of each room. The rooms could be changed from negative to positive pressure according to the patient's requirements.

The hospital did not routinely use care plans for patients with a known or suspected infection. The only exception for this was on Ward 28 where patients with multi-drug or extremely drug resistant tuberculosis who were undergoing directly observed therapy, short course (DOTS) management to ensure they were complying with their treatment had an individualised care plan developed for them.

All patients who were admitted into the ward areas received a daily wash with a solution which is usually used in the management of MRSA patients (it reduces the bacteria on the skin, therefore reducing the risk of patients acquiring any serious infections). The solution was held in central locations (by the sink) and used for multiple patients, patients in single rooms had their own bottles allocated to them. Staff were responsible for ensuring all patients received an appropriate amount for their wash as well as ensuring the bottles did not enter individual patient bed spaces. However, this solution is supposed to be used directly on to the patient’s skin and not diluted into water. Staff we spoke with told us the bottles absolutely did not leave the sink area, however could not provide assurance around this.

The hospital participated in ‘Patient-Led Assessments of the Care Environment’ (PLACE). PLACE are a self-assessment of non-clinical services which contribute to healthcare delivered in both the National Health Service (NHS) and independent/private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The assessment of cleanliness for this
hospital demonstrated a compliance level of 98.8% which was about the same as the England average of 98.5%.

Throughout the hospital, privacy curtains were disposable. Nursing and housekeeping staff told us the schedule for changing them was six monthly but they were changed if visibly soiled or following patient isolation. The disposable curtains had dates on them indicating when they were put up and routine changes were scheduled every four months. This was in accordance with Health Building Note 00-09: Infection control in the built environment regulations which states; there should be a local policy on the changing of privacy curtains, both for routine changing when the curtains become soiled and after the discharge of a patient with a known/or suspected infection.

Senior nursing staff were aware of the trust policy regarding tap flushing for legionella infection prevention. Legionella is a waterborne bacterium, which causes legionnaires disease. Designated staff members were responsible for flushing infrequently used taps and showers on a frequent basis and recorded this electronically to monitor compliance. Water testing was completed across the hospital and any areas found to be of higher risk were subject to increased flushing and recording.

Environment and equipment

All wards and departments were designed in accordance with Department of Health Guidance Health Building Note (HBN) 04-01: Adult in-patient facilities and included for example, appropriate patient and staff facilities to keep people protected from avoidable harm. We observed that piped air had recently been removed from all patient bays and single rooms in a response to a recent incident. Some of the ward areas had seen recent internal improvements (Ward 26 had four single rooms improved due to ventilation update requirements), other areas were visibly older but all appeared well maintained. The endoscopy department was compact and there were plans in place for a new department to be built which was more purpose built and would meet the demands being placed on the department.

We reviewed the resuscitation trolleys on four wards and found on three of these wards the trolley had been checked and recorded daily, however on one ward, we observed several days where staff had not recorded a check of the equipment. All consumable equipment within the draws of the trolleys were in sealed bags with the earliest expiry date clear on them. When used, these bags were re-packed and sealed, with the expiry date written on them. All bags and equipment within them were found to be within the expiry date. Resuscitation trolley checks were part of the ward matrix which ward managers completed on a monthly basis.

We reviewed 38 items of equipment which included hoists, blood pressure machines, electrocardiogram (ECG) machines, defibrillators, suction units and scales and found most items had evidence of a service and electrical safety testing, however three of these items either did not have an in-date test or the sticker displaying the next date for testing was missing/blank. Patient equipment we reviewed was appropriately maintained.

On all wards we visited, we found chemicals were not stored in line with Control of Substances Hazardous to Health (COSHH) Regulations 2002. All sluices had bottles of chlorine based solutions made up and left on the side. Although the solutions complied with the requirements for being made up (made daily with time and date evident on the bottles) these should be locked away to ensure unauthorised personnel do not have access to them. Alcohol hand gel was stored in various places we saw some in linen cupboards and two bottles next to a hand wash basin out on the ward. We also, did not see COSHH information or data sheets available on wards.
All patients who were deemed at risk of pressure damage had access to appropriate pressure relieving equipment including cushions and mattresses.

We observed clinical and domestic waste was correctly segregated and waste bins provided for the wards were compliant with health technical memorandum (HTM) 83 as they were fire retardant as well as being enclosed and foot operated which are requirements under the larger waste management guidance document HTM 07-01 safe management of healthcare waste. The management and disposal of sharps was completed in accordance with trust policy in all places that we visited. Clinical specimens were collected according to trust policy and was either collected by authorised staff or sent through an internal tube system to the laboratory. For high risk samples, staff on Ward 28 were aware of the actions they needed to take which included placing specimens into protective external containers and taken to the laboratory directly to ensure safe delivery. Liaison with external specialist laboratories would be required to ensure any other additional measures required were taken and timely delivery to them, and minimal risk to other staff members during transit was adhered to.

Assessing and responding to patient risk

The hospital adopted a safer patient/placing system where patients from the Emergency Department (ED) or the acute medical unit (AMU) were placed on the wards to make space for new patients being admitted to the department at times of high activity. The wards were not always given the opportunity to be involved in patient selection so were unable to complete risk assessments to ensure the patients placed with them were appropriate for their ward areas. Staff told us the only input they could insist on was whether the area identified for the additional patient to be ‘placed’ was suitable or not for a patient with oxygen. During our inspection, we saw seven patients in a bay which was meant for six patients, with the additional patient being in a non-bed space.

Staff told us this safer patient/placing system was deemed as a significant risk to their wards and increased the pressure placed upon them. At times, some wards had experienced more than one additional patient being placed with them.

A Modified Early Warning System (MEWS) was used for patients across the hospital to assist staff in the early recognition of a deteriorating patient. MEWS is a guide used by medical services to quickly determine the degree of illness of a patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient’s condition was deteriorating. We saw MEWS documentation was completed appropriately which meant that patients were being monitored for signs of deterioration and could be treated in a timely way.

During our inspection we reviewed 15 patient observation charts across three clinical areas. Nursing staff adhered to trust guidelines for the completion and escalation of MEWS. All charts reviewed had full observations recorded which included blood pressure (BP), heart rate, respiratory rate, SPO2 (an estimate of the amount of oxygen in the blood), temperature and urine output. Pain scores were recorded on all charts reviewed. MEWS had been completed correctly at each time of recording the patient’s observations. If patients required fluid balance charts, all of these were up to date and accurately calculated. Patients scoring on their MEWS were required to have further set of observations recorded within a set timescale for example from four hourly to one hourly. Of the 15 charts reviewed, all patients had observations performed in line with the trust ‘escalation of MEWS monitoring in adult patients’ with the exception of one patient who was not for escalation. Ward matrix information provided by the trust showed wards generally escalated patients when they had a MEWS score of four or above, with only two months
indicating compliance of below the 95% expected standard (November 2017 and August 2018).

Staff had received sepsis awareness training when the sepsis proforma was originally rolled out, however most staff told us they had not received any further training since this. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs. There is strong evidence that the prompt delivery of ‘basic’ aspects of care detailed in the Sepsis Six Bundle prevented prolonged treatment and had been shown to be associated with significant mortality reductions when applied within the first hour. Staff knowledge of sepsis and the sepsis pathway was variable from ward to ward and this was reflected in the sepsis screening for patients who had an infection or heightened MEWS. Senior nursing staff told us they were confident all nursing staff would be aware of the requirement for escalating heightened MEWS scores, however due to lack of on-going awareness training, they would not necessarily think the patient may have sepsis.

We reviewed 15 sets of notes and observations for patients with possible sepsis and found nine (60%) of these had a sepsis proforma completed and where necessary the sepsis six bundle had been fully implemented. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality (death) of patients with sepsis, it consists of three diagnostic and three therapeutic steps, all to be delivered within one hour of the initial diagnosis of sepsis for example administering oxygen and intravenous (IV) antibiotics. The remaining six showed either no evidence of a sepsis screen being completed using the hospital proforma or there was no evidence, where required, the complete bundle had been initiated or initiated within the recommended hour. Ward matrix information provided by the trust showed inconsistent results between September 2017 and September 2018. One element which wards were assessed against was ‘septic patients being assessed and discussed within 30 minutes’, for this element, wards achieved the required compliance level for 11 out of 13 months. However, on another element which they were assessed against (sepsis screening considered for MEWS score of four or above) wards achieved 100% compliance for five out of 13 months. Information showed compliance within the wards areas ranged between 50% to 100%, with September 2018 demonstrating 94% compliance.

Staff took the time to identify and respond to the changing risks of patients. For example, the adult inpatient care risk assessment booklet included a tissue viability assessment and pathway. Patients assessed as at risk had a pressure-relieving mattress ordered on the day of admission. This ensured that patients at risk of possible skin damage were identified early and risks could potentially be reduced. The admission booklet also contained a falls multifactorial assessment that included for example, patient history, footwear and eyesight assessments. This ensured all factors that could contribute to a patient’s risk of falls were reviewed.

We reviewed 33 nursing notes which contained a risk assessments document. Within this document, there were risk assessments for falls, manual handling, skin integrity, malnutrition, continence, mental health, pain and bed rails. All risk assessments had been completed within 24 hours of admission and most had evidence of on-going assessment of the patient, with the exception of four where additional on-going assessment was not completed.

Falls risks had been an area of on-going risk identified in a number of ward areas. Patients deemed at risk of falls were mainly managed by allocating them a bed which was highly visible to staff members (near the nurse’s station), allocating a member of staff to remain in the location where the vulnerable patient(s) were admitted or placing the patient on a special bed which went all the way down to the floor. Senior staff on Ward 28 had also purchased sensor cushions which patients sat on due to high numbers of falls in previous months. Since the introduction of these devices, the number of falls had reduced significantly.
A critical care outreach team (CCOT) was available 24 hours a day, seven days a week. The team worked closely with the nursing and medical teams in the intensive care units within the trust and supported ward staff in the detection and management of critically ill and deteriorating patients. The aim of CCOT was to ensure deteriorating patients received appropriate and timely treatment in a suitable area.

We reviewed 23 sets of medical care records. Where patients’ were admitted as an emergency, they had been seen and assessed by a consultant within 12 hours of admission and assessed by a member of the medical team within 30 minutes. This was in line with national guidance.

Staff had access to mental health liaison and/or other specialist mental health support if they were concerned about risks associated with a patient’s mental health. We saw posters in all departments about how to contact the liaison psychiatry team (RAID- rapid assessment interface and discharge).

Any patient admitted for self-harm or overdose had an automatic referral to the RAID team. Staff we spoke with told us that if they were concerned about a patient’s mental health or wellbeing then any staff member could contact the RAID team for advice. All staff told us the RAID team responded quickly and ward staff speak highly of them.

Patients who required non-invasive ventilation were allocated a bed on the Respiratory Ward (Ward 24). Non-invasive ventilation (NIV or ‘mask ventilation’) is a way of helping a person to breathe more deeply by blowing extra air into the lungs via a mask when they breathe in. This ward had 13 beds allocated for patients requiring NIV and was physiotherapy led with nurses working alongside them who had completed additional competencies to care for these patients. Three registered nurses with NIV competencies were allocated to work in this area on each shift. If the acuity of the ward elevated above 30, additional staff were requested to ensure all patients were cared for in a safe environment. British Thoracic Society guidelines state patients being initiated on non-invasive ventilation (NIV) should be identified as requiring Level two care and have increased nurse staffing levels that equate to 1:2 nurse to patient ratio for the first 24 hours. Staff ensured this occurred for those patients who were within the first 24 hours of NIV treatment.

During our inspection, the ward manager had recently submitted the acuity for the morning and was calculated to 29 at that point. If patients were admitted through the emergency route, AMU would admit patients for a short period of time however only if chest physiotherapists were available to lead on their care. Staff on AMU were aware that if they required additional support or advice, staff from Ward 24 could be contacted.

The Respiratory Ward had recently started to admit patients with a tracheostomy. This change had occurred since the acquisition occurred earlier this year. Staff had received additional training to care for these patients, however this change to the ward patients had meant the acuity had risen very suddenly. All patients with a tracheostomy had emergency equipment by their beds for staff to use if their airway failed. Staff were familiar with the emergency process although at the time of our inspection had not had any encounters where emergency equipment had to be used.

Patients undergoing endoscopy procedures and procedures in the cardiology department had checklists completed which incorporated an adapted World Health Organisation (WHO) checklist and locally adapted safety standards for invasive procedures (LocSSIPS). We saw evidence of these checklists being completed well.

There was a process in place for patients who became unwell during an endoscopy procedure. Staff in the department were able to explain the process well and also gave us examples of when patients required a hospital admission in the past.
Staff told us patients who underwent procedures in the angio-catheter suite did so under conscious sedation (verbal contact is maintained throughout the duration of sedation). During our inspection, we did not observe any patients undergoing conscious sedation, however staff told us there was a member of staff solely responsible for monitoring the patient should conscious sedation be administered. This was in line with the Royal College of Anaesthetists guidance for the provision of sedation.

**Nurse staffing**

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in medicine.

The overall fill rate for qualified nursing staff remained similar at 85.7% in March 2018 and 83.3% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>919.5</td>
<td>966.8</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>528.1</td>
<td>640.4</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>266.0</td>
<td>384.7</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>192.2</td>
<td>235.4</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

All wards used nationally recognised tools for setting and reviewing the establishment for staffing. This was reviewed regularly and the most recent establishment for medical wards was identified as above. All wards we visited displayed the planned and actual staffing information for the day and we found these to be true representations of staffing during the shift.

All ward managers were responsible for forwarding their staffing vacancies on a shift basis to their divisional leads. If there were staffing shortages on the shift, the divisional leads were responsible for escalating and managing this. Staff from the site manager team told us they were not responsible for managing staffing across the site.

Staffing within the coronary care unit (CCU) was always scheduled so there would be two patients to one nurse. The CCU also ensured a senior nurse of band six or above was on each shift and took charge of the unit.

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 17.3% for nursing staff in medicine. This was higher than the trust target of 5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors vacancy rates for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:
• Queen Elizabeth Hospital: 9.5%
• Birmingham Heartlands Hospital: 17.7%
• Good Hope Hospital: 26.6%
• Solihull Hospital: 15.2%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Without exception, staff from all wards we visited told us they had large vacancy rates on them. Vacancy rates varied between 10 and three vacant registered nurse posts. All staff told us this had significantly impacted on the wards and the pressures placed upon them due to additional workloads on shifts. Senior staff told us they had been involved in many recruitment events including attending the local university to promote the hospital to student nurses coming to the end of their courses, however these events had not always been successful. One ward (Ward 3) had recently been able to recruit five newly qualified nurses who would be starting imminently, so they were confident this would ease some of the pressures on there.

There were also some wards experiencing vacancies with unregistered staff (healthcare assistants). However, most staff acknowledged they had been able to recruit into these posts easier than they had with their registered vacancies. One ward had three new healthcare assistants starting imminently to bring them back up to establishment for this staff group.

In most ward areas we visited, the vacancy of posts did not appear to impact on the patient care being provided, although staff were busy, patients were receiving care and treatment in a timely, safe and dignified manner. However, we did observe two wards (Ward 2 and 30) where the impact of staffing vacancies and low staffing levels on the day were impacting on patient care. We observed patients requiring assistance with activities of daily living (toileting) and patients who had exposed themselves. We also observed many buzzers sounding from patients who required assistance, but staff were unable to leave them due to already being with patients. One staff member told us they felt really upset they were unable to answer a buzzer, however they were observing a patient who was high risk of falls. We escalated the issues on Ward 30 to the senior executive team, who took immediate action.

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 9.7% for qualified nursing staff in medicine. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:
• Queen Elizabeth Hospital: 4.2%
• **Birmingham Heartlands Hospital: 14.9%**
• Good Hope Hospital: 15.5%
• Solihull Hospital: 16.6%
• Community locations: 13.2%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Staff told us they had noticed a lot of nursing staff leaving their ward areas, majority of which had
been in post for a substantial amount of time and had skills and competencies which were required for working in the areas, this therefore impacted at times with skill mix on shifts. Reasons for leaving the wards were varied, some staff had left to further their own careers through promotion or for a specialist post, however we were told by staff that members of their team had left for personal reasons and uncertainty of their future due to being recruited on overseas programmes.

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 4.7% for qualified nursing staff in medicine. This is above the trust targets of 3.6% for Queen Elizabeth Hospital and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

- Queen Elizabeth Hospital: 4.5%
- **Birmingham Heartlands Hospital: 5.4%**
- Good Hope Hospital: 4.2%
- Solihull Hospital: 4.7%
- Community locations: 2.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Birmingham Heartlands Hospital had the highest number of staff on sickness across the whole trust, however during our inspection, staff did not highlight staff sickness as a significant issue. There were areas which experienced higher levels of sickness than others, however the overall vacancy picture for the wards were the main concern.

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From April 2017 to March 2018 the trust reported 13,503 shifts were filled by agency staff, 70,581 by bank staff and 40,565 shifts were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>3,090</td>
<td>53,472</td>
<td>31,820</td>
</tr>
<tr>
<td>Other sites</td>
<td>10,413</td>
<td>17,109</td>
<td>8,745</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Staff told us they had mainly been using their own staff who had joined the hospital bank to fill any vacant posts on shifts, however since the acquisition had occurred, there was a significant number of staff leaving the bank due to the changes to bank pay. Staff had told us this was starting to impact on their requests for agency staffing and their slight incline in reporting shifts which they had been unable to fill.

Staff on wards where bank staff had not been able to be arranged to fill all outstanding vacancies on shifts, wards had started to ‘block book’ agency staff. This ensured consistency of staff
members who knew the wards and also ensured the wards got the right skills they required to enhance the staffing for the shift.

**Medical staffing**

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in medicine.

The overall fill rate for medical staff dropped from 89.3% in March 2018 to 88.2% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td>Fill Rate</td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>staff – WTE</td>
<td>staff – WTE</td>
<td></td>
<td>staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>317.2</td>
<td>321.8</td>
<td>98.6%</td>
<td>339.9</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>225.0</td>
<td>251.1</td>
<td>89.6%</td>
<td>217.3</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>75.3</td>
<td>110.8</td>
<td>68.0%</td>
<td>71.8</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>62.6</td>
<td>78.0</td>
<td>80.2%</td>
<td>61.4</td>
</tr>
</tbody>
</table>

Queen Elizabeth Hospital was over staffed in June 2018 with 3.9 WTE higher than planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 11.8% for medical staff in medicine. This was higher than the trust target of 10% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors vacancy rates for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: -0.9% (over staffed)
- Birmingham Heartlands Hospital: 10.1%
- Good Hope Hospital: 28.7%
- Solihull Hospital: 16.0%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 4.2% for medical staff in medicine. This is below the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:
• Queen Elizabeth Hospital: 2.3%
• Birmingham Heartlands Hospital: 11.1%
• Good Hope Hospital: 12.4%
• Solihull Hospital: 10.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 0.8% for medical staff in medicine. This is below the trust targets of 3.6% for Queen Elizabeth Hospital and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

A breakdown by site is below:

• Queen Elizabeth Hospital: 0.8%
• Birmingham Heartlands Hospital: 0.6%
• Good Hope Hospital: 0.7%
• Solihull Hospital: 1.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

We spoke with eight medical staff during our inspection. They told us they felt well supported and well staffed during day shifts, however there was a noticeable difference on night shifts with short notice sickness. This impacted on the support which was available to them during this shift.

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From April 2017 to March 2018 the trust reported that 15,816 shifts were filled by locum medical staff, 7,741 by bank medical staff and that 3,125 were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Locum</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>4,959</td>
<td>2,574</td>
<td>752</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>3,707</td>
<td>2,784</td>
<td>678</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>6,263</td>
<td>1,267</td>
<td>1,559</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>887</td>
<td>1,116</td>
<td>136</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

**Staffing skill mix**

In May 2018, the proportion of consultant staff and junior (foundation year 1-2) reported to be working at the trust was similar to the England average.
There were two consultants trained in acute internal medicine available on the Medical Assessment Unit during the day Monday to Friday. Out of hours and at weekends consultants were on call and able to reach the unit within 30 minutes.

Three doctors trained at level ST3 or above were available on the unit at all times. All three had up-to-date competences in advanced life support.

Consultants in cardiology completed a daily ward round for patients admitted. Consultant cover of the department at weekends was on a one in eight rota.

Arrangements for handovers and shift changes ensured that patients were protected from avoidable harm. On the Medical Assessment Unit, the medical handover of emergency medical admissions occurred twice daily (9am and 5pm). We observed a medical handover where all overnight admissions were reviewed first by a consultant, followed by the remainder of patients. A comprehensive medical review of each patient took place and included appropriate escalation of those patients who were at risk of clinically deteriorating, sepsis and a review of diagnostic tests.

**Records**

All wards used paper based notes for inpatient admissions, at the time of our inspection, there was minimal information stored electronically for patients. However, since the acquisition had occurred, staff were aware of the advancements in record keeping at one of the other locations and the plans for this hospital (Birmingham Heartlands) to become aligned with their technology. Staff however, were not aware of the timeframes for this to occur.

Paper based risk assessments and observation charts were stored at the end of the patient beds (or outside single rooms when patients were isolated) for ease of access at point of care. Daily updates by nursing staff and allied health professionals were written in the patient’s main medical notes which were kept in trolleys near the nurses station. In most circumstances, these trolleys were locked, however we did find some trolleys which were unlocked during our inspection. We also observed in some ward areas there had been patient records left out of trolleys as well as stacks of files being placed in unlocked ward administrator’s offices. Senior staff acknowledged this was not usually the case, however due to ward administrator leave, the number of notes were mounting up and therefore not secure.
We reviewed 23 sets of complete notes as well as 15 additional observation charts and sepsis proformas during our inspection. We found on the whole records were legible, contemporaneous, signed and dated and contained specific details about patients care. We also found on the whole risk assessments were regularly reviewed and updated, with the exception of four which we only saw evidence of initial risk assessment. However, we occasionally found entries which although signed, had no printed name to accompany the signature, and also medical staff did not always enter their GMC number which was not in line with professional standards. We also found the nursing staff did not necessarily complete traditional individualised care plans. The risk assessment document had areas within them for staff to document when there was on-going input for example, the continence risk assessment and skin integrity risk assessment identified when additional needs were required for a patient in regards to products and equipment, and for patients with skin integrity issues, a body map was included however these were not evidence based care plans which staff reviewed and updated on each shift. Staff also told us there were no individualised care plans used for patients who were considered to be end of life or last days of life.

When appropriate, records contained details of patients’ mental health needs alongside their physical health needs. We reviewed five sets of medical/nursing records and saw where the patient’s mental health needs had been identified and managed appropriately.

We reviewed three electronic medicine administration records, where patients were prescribed an antimicrobial (antibiotic), and all three demonstrated they had the clinical indication, dose and duration of treatment documented in their clinical record.

On Ward 24, one of the senior nurses had launched a local documentation initiative to ensure all nursing staff used a standardised approach to documenting about patient care and treatment whilst under their care and responsibility. They had used the ‘POINTS’ acronym which stood for pressure, observations, infection control, nutrition, toileting and socks. Through using this acronym, it ensured all the pertinent points of patient care was covered and displayed in a logical order for all staff to review and digest. This initiative was implemented following a significant complaint which the ward investigated. They told us they found it difficult to investigate the concerns in the complaint due to the poor documentation standards of some staff members who had looked after the patient. Currently, the initiative was only local, however the ward manager had presented this to other members of the hospital and feedback was positive, with other managers looking to adopt it for their wards.

**Medicines**

Medicine errors, including those resulting in harm, were reported as part of the incident reporting process. Medicines incidents were reported on a monthly basis to the medicine safety group.

The top two reasons for raising incidents were omitted medicine and wrong dose prescribed.

Staff were able to discuss incidents where errors had occurred and described the actions taken to help prevent a similar error.

Wards were visited by a pharmacy technician daily and usually a pharmacist. If there were concerns outside of the usual visit time, staff could be bleeped. The Discharge Lounge had a permanent pharmacy technician in order to improve timely discharges from the area.

Controlled medicines are medicines controlled under the Misuse of Drugs regulations 2001 these legal controls govern how controlled medicines should be stored, produced, supplied and prescribed. Quarterly audits of controlled medicines took place at the trust and information for each ward was communicated to the ward leaders. We reviewed controlled medicines records on
six wards at Heartlands Hospital. Medicines were stored appropriately and records were accurately completed.

There were local microbiology protocols for the administration of antibiotics. The pharmacist monitored antibiotic prescribing to ensure patients were prescribed antibiotics in accordance with these protocols and a microbiologist was available to advise doctors with antimicrobial selection.

Inspectors reviewed electronic medication charts for eight patients and found them to be complete, up to date, and reviewed on a regular basis. The electronic prescribing system directed prescribers with correct prescribing of all medicines.

Patient’s weight and any allergies were also recorded. Records showed patients were getting their medicines when they needed them. We observed nurses administering medicines, checking doses and names. Nurses wore red aprons to indicate they were carrying out medicine rounds and should not be disturbed.

Staff knew about the five rights of medicines administration. One of the recommendations to reduce medicine errors and harm is to use the “five rights”: the right patient, the right drug, the right dose, the right route, and the right time. (Institute for Healthcare Improvement 2007).

Disposal arrangements were in place for out of date medicines, or medicines, which were no longer required. Medicines were disposed of in grey medicine disposal bins or returned to pharmacy.

Intravenous fluids were stored in locked cupboards in store rooms on wards. This reduced the risk that intravenous fluids could be tampered with or accessed by unauthorised people. However, on all four wards we reviewed intravenous fluids were stored on the floor and were not segregated into plain fluids and fluids with additives. This increased the risk of maladministration.

Medicines requiring refrigerated storage were not always stored at the correct temperatures to ensure they were fit for use. On all of the wards we inspected, the temperature checks for the medicines fridges were undertaken by the ward teams. Fridge temperatures were recorded, including current lowest, highest and actual. However, on three out of four wards the highest temperatures exceeded the recommended temperature for the medicines. Because of this, we could not be assured medicines were stored safely. Staff we spoke with on the wards had not questioned or rectified the high temperature readings. Ward matrix information provided by the trust also showed their own performance for refrigerator temperature monitoring was not consistent, with eight out of 13 months (September 2017 to September 2018) not achieving satisfactory monitoring results. Out of the 13 months, all wards only achieved 100% compliance for two months.

We reviewed room temperature records during this inspection and found in all areas that the high reading mostly exceeded the safe room temperature for medicines storage. However, on the Acute Medical Unit (AMU) staff reported high room temperatures to pharmacy and were given instructions regarding the safe use or disposal of all medicines to ensure patient safety.

We found bottles of liquid medicines on four wards which did not have the date when opened recorded on them. This is not in keeping with recommended best practice for storage of medicines.

On most wards, we found oxygen cylinders were stored securely in appropriate and purpose-built storage to ensure they remained upright, and were stored in well ventilated areas. This is in line with the Health and Safety Executive (HSE) guidance. However, on Ward 2 we found three oxygen cylinders which were not stored in accordance with HSE guidance as they were loose on...
the ground in a store room. We informed the staff on the ward of this at the time of our inspection who took steps to rectify this.

Medicines for the emergency treatment of hypoglycaemia were available on each ward in an easily identifiable container. All medicines were found to be in date.

**Incidents**

The service used an electronic incident reporting system. This system and the policy used on all wards at this hospital was the old system which was in place prior to the acquisition, however staff were aware there were planned changes due to take place with the incident reporting system. All staff were knowledgeable about the current process and had previously used the incident reporting system, however, some nurses we spoke with during our inspection were no longer submitting incident reports for minor issues and staffing or safer patient placing due to apparent lack of action taken after they did submit incident reports and the lack of time they had to complete an incident report. One member of staff also told us the incident form had changed and for the most common element which they had reported before (staffing), they were no longer able to do this simply and so was reluctant to report poor staffing levels anymore.

The duty of candour is a regulatory duty that relates to openness and transparency and requires Providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Following the acquisition within this trust, the duty of candour policy for Birmingham Heartlands Hospital was currently under review. However, staff we spoke with were familiar with the principles of duty of candour and the concept around being open and honest. From April 2017 to March 2018, there was a total of 192 times when the medical core service for the trust had implemented the duty of candour. Following completion of an investigation the patient or their representative were asked how they wished to receive the findings.

As a result of learning from previous incidents involving patients falling whilst admitted, all patients who underwent a fall on the medical wards had a ‘falls notification form’ completed by the medical staff. Included on this form was an area which covered the principles of duty of candour, and gave staff the opportunity to record when the patient and their next of kin had been spoken with about the fall and where applicable, an apology had been made by staff. We were also given examples by staff where they had completed the duty of candour process following a serious incident around delay in diagnosis.

The trust reviewed most inpatient deaths using an internal medical examiner. The exception to this was those patients where forensic and coronial investigations were required. If possible, learning was identified in these deaths, they would be discussed in other governance and quality group meetings as well as speciality mortality and morbidity meetings.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.
From August 2017 to March 2018 the trust reported one incident classified as a never event for medicine.

This occurred at Birmingham Heartlands Hospital in March 2018 and related to a medication incident where a patient requiring oxygen was unintentionally connected to an air flowmeter.

(Source: Strategic Executive Information System (STEIS))

The never event occurred on Ward 28 (Infection Diseases and Tropical Medicine Ward). Although this occurred in March 2018, this was not reported until June 2018. Staff on all medical wards were aware of this incident and the learning which has come locally from this incident. Although the incident was still under investigation by the trust, there had already been actions put in place to ensure further occurrences would not happen. The piped air had recently been withdrawn from all wards at Heartlands Hospital and wards were purchasing equipment to use (nebulisers) which they had previously used the piped air for.

Breakdown of serious incidents reported to STEIS

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 78 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2017 to July 2018.

The breakdown by type of incident reported were:
- Slips/trips/falls with 36 (45.6% of total incidents)
- HCAI/Infection control incident with 32 (41.0% of total incidents)
- Pressure ulcer with six (7.7% of total incidents)
- Treatment delay with two (2.6% of total incidents)
- Surgical/invasive procedure with one (1.3% of total incidents)
- Medication incident with one (1.3% of total incidents)
Site specific information can be found below:
- Queen Elizabeth Hospital (August 2017 to July 2018): 60 incidents
- Good Hope Hospital (April to July 2018): 11 incidents
- Birmingham Heartlands Hospital (April to July 2018): five incidents
- Solihull Hospital (April to July 2018): two incidents

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 63 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2017 to March 2018.

The breakdown by type of incident reported were:
- Slips/trips/falls with 25 (39.7% of total incidents)
- Pressure ulcer with 21 (33.3% of total incidents)
- HCAI/Infection control incident with nine (14.3%)
- VTE with two (3.2% of total incidents)
- Sub-optimal care of the deteriorating patient with two (3.2% of total incidents)
- Medication incident with two (3.2% of total incidents)
- Diagnostic incident including delay with one (1.6% of total incidents)
- Confidential information leak/information governance breach with one (1.6% of total incidents)

Site specific information can be found below:
- Good Hope Hospital: 30 incidents
- Birmingham Heartlands Hospital: 26 incidents
- Solihull Hospital: seven incidents

*(Source: Strategic Executive Information System (STEIS))*

All serious incidents and never events were subjected to thorough investigation, which allowed areas for improvement and learning to be identified and disseminated through relevant local and trust wide governance meetings.
Information received from the trust showed from October 2017 to September 2018, there were 5,474 incidents reported for the services included within the medicine core service. The majority of these were graded as no harm (4,276 incidents). Of the remaining 1,198 incidents, 1,108 were graded low harm, 61 were graded medium harm, 22 were graded severe harm and six were graded as catastrophic. There was an additional one incident reported during this time which was recorded as a near miss. The three most common themes for incidents which were reported during this time was pressure sores (1,383 incidents), patient falls (1,108 incidents) and incidents involving security staff (514 incidents).

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported 117 new pressure ulcers, 45 falls with harm and two new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Heart of England NHS Foundation Trust**

![Graph 1: Total Pressure Ulcers (117)]

1. Total Pressure Ulcers (117)

![Graph 2: Total Falls (45)]

2. Total Falls (45)
Is the service effective?

Evidence-based care and treatment

Patient care was delivered in line with trust policies and pathways based on national guidance including for example, National Institute for Health and Care Excellence (NICE) and British Thoracic Society guidance. Policies and pathways were available to staff and accessible on the trust intranet site.

However, we did not see care plans and pathways available for any conditions including for example, falls, pressure ulcers, stroke and sepsis.

The trust’s assurance process regarding NICE guidance was set out in the trusts NICE Guidance Implementation Policy (Oct 2017).

We were told all new NICE Guidelines were implemented at the end of each month and were sent to clinical leads for each Specialty. A three month period for leads to respond was then issued, by which time feedback and baseline tools were expected.

Baseline tools provided by NICE were used as resources to ensure that monitoring of the recommendations were taking place. The trust ensured measures were taken to abide by all recommendations outlined in the guideline’s. If clinical leads did not respond to emails, there was an escalation process to gain a response.

The trust provided a compliance status against the following guidance’s: Public Health guidelines, Medical Technologies, Diagnostics Guidance, Cancer Services Guideline, Technology Appraisals, NICE Guidelines, Clinical Guidelines and Interventional Procedures Guidelines. The latter three were accompanied by Baseline Assessment Tools and all others were sent for GAP analysis to identify any shortfalls and compile an action plan.

Medical services participated in national benchmarking clinical audits such as, the Sentinel Stroke National Audit programme (SSNAP), Lung Cancer and National Inpatient Falls Audit. Local audits included, antibiotic duration and prescribing, peripheral vascular access devices and ‘5 moments of hand hygiene’. Where compliance was shown to be below target action plans were agreed and implemented.

There was a trust policy for the management of patients detained under the mental health act. This outlined the process to ensure the rights of patient’s subject to MHA detentions were
supported. Information was provided to the patient on application of the detention, which explained their rights. In addition, the trust had an agreement with the ‘Mental Health Act Office’ operated by a local NHS mental health trust whereby they maintained a database of all approved detentions and quality assured all trust MHA applications to ensure that patient’s rights had been explained and arrangements had been made to access advocacy services if required. Staff also informed us of a Mental Health Resource page which was available on the intranet and had all the supporting documentation.

Older patients who were frail or vulnerable received (or were referred for) a comprehensive assessment of their physical, mental and social needs.

Patients on the Acute Medical Unit were seen and reviewed by a consultant twice daily. To maximise continuity of care consultants worked multiple day blocks. Once transferred from this area to a general ward, patients were reviewed during a consultant-delivered ward round at least once every 24 hours Monday to Friday. At weekends, a consultant did not routinely review patients unless they were admitted at the weekend, there was concern, or their condition was deteriorating.

The endoscopy unit was accredited by the Joint Advisory Group (JAG) for GI Endoscopy. This meant care, treatment and procedures had been assessed to be delivered in line with international best practice standards and were regularly assessed and audited. The accreditation was an indicator of high quality performance and standards in line with those set by the international global ratings scale.

There were pathways in place for patients requiring primary percutaneous coronary intervention (PPCI) and patients experiencing a non-ST segment elevation myocardial infarction (NSTEMI which is a type of heart attack). PPCI is a non-surgical procedure that uses a catheter (a thin flexible tube) to place a small structure called a stent or balloon to open up blood vessels in the heart. This ensured patients received care which was evidence based and considered as best practice.

**Nutrition and hydration**

Fluid balance charts were in place to monitor patients’ hydration. We reviewed eight fluid intake and output charts and found that all were fully completed. This meant that patients’ fluid requirements were monitored accurately in the sample we checked.

All patients had their nutritional status assessed within 24 hours of admission using the malnutrition universal screening tool (MUST). The MUST tool calculates the overall risk of malnutrition. Patients considered a lower risk of malnutrition were scored and a prompt was given for nurses to assess and monitor then repeat the assessment after three days.

The booklet then advised the nurse further on what to do in certain circumstances. For example, if the patient had swallowing difficulties refer to the Speech and language therapy team. New staff had training during induction on the use of the MUST tool.

Ward staff told us that although a dietitian did not necessarily visit the wards daily they knew how to contact the team if necessary. The assessment and MUST tool offered a guide to assist the nursing staff in deciding if a dietitian referral was required. Staff told us that dietitians were easily accessible and responded promptly to referrals from nursing staff.

We reviewed 20 food charts across all wards we visited, we found all were fully completed.

Results from the 2018 PLACE (patient led assessments of the care environment) audit showed Heartlands Hospital had achieved 91.7% overall for their food and hydration assessment which was slightly better than the England average (90.2%). They scored 92.8% for their ward based
food assessment which was above the England average of 90.5%, this part of the assessment reviewed the taste, texture and temperature of the food being served to patients. However, they scored 87.4% for their organisational food which was below the England average of 90%. This part of the assessment reviewed the catering services, 24-hour availability of food for patients, meal times and availability of menus.

Meal times were open on all wards for relatives to attend and help the patient with their nutritional needs. Staff told us having open visiting at meal times had been positive for patients and they observed how patients had an increase in their nutritional uptake when relatives visited and helped them.

**Pain relief**

There was a pain assessment included in the generic risk assessment document which all patients had completed on admission. From this initial risk assessment, staff were able to assess what input a patient would require from a pain perspective. If a patient was in severe pain on admission, a referral to a pain specialist would be considered.

A numerical pain assessment tool was used on all wards and recorded on the observation chart. Patients were asked to rate their pain between zero (no pain) and three (severe pain). We reviewed 15 observation charts and found evidence of regular pain assessments for all patients. Information on the ward matrix which was provided by the trust showed all wards were continually meeting the requirements relating to pain assessment between September 2017 and September 2018.

On most wards, there were provisions in place to assess the pain of patients who could not verbalise a pain score. On Ward 21, all bedside folders had pictorial pain charts and phrases in languages other than English to indicate a patient was in pain. Staff told us they would use these for patients in appropriate circumstances.

All patients we spoke with told us they received medication to relieve their pain if they required this.

**Patient outcomes**

Patient outcomes were monitored through participation in national and local audits in the medical service. National audits which the service had participated in were sentinel stroke national audit, lung cancer audit and the national inpatient falls unit. Senior medical staff on Ward 26 (cystic fibrosis ward) also told us they submitted data to a national standards of care audit as well as completing local audits of patient care. We requested the most recent results of the audit conducted, however the information provided did not show this. The trust did however provide results of the CQUIN data for 2018 which they are required to provide on patients admitting to the hospital with cystic fibrosis. The trust were required to provide data on how many patients were admitted per month, of these how many were admitted directly into a sideroom, how many were admitted on to the specialist ward, number admitted within 24 hours and number of patients who breached. The information provided showed the trust were meeting the requirements for most elements, most months, apart from January and February where there were two breaches.

Staff were knowledgeable about local audits which had occurred in the service, with some staff participating in the collection of data. One senior medical member of staff told us about a continuous audit of the delirium pathway. The most recent audit which was completed identified an area which required amending to improve the efficacy of the pathway. Simultaneous to this audit which was conducted, information about the care and treatment for delirious patients was submitted for a national benchmarking audit for delirium management. The results of this audit
were not yet available, however the staff member told us this was an exciting opportunity to gauge how well care was provided for patients who were delirious.

Nursing staff collected data and recorded them for specific topics on the clinical matrix. This was regularly reviewed and where areas for improvement identified, a plan of action was completed and disseminated amongst staff. Areas which were assessed on a monthly basis was environment, resuscitation trolleys, patient safety and dignity, observations, fluid balance, tissue viability, nutritional assessment, falls assessment, manual handling, continence assessment and blood glucose monitoring.

Staff in the coronary care department monitored their performance with patients being admitted with a non-ST segment elevation myocardial infarction receiving treatment. Current data showed 66% of patients received treatment in the cardiac catheter laboratory within 72 hours. This is significantly lower than the expected standard of 100% identified in the relevant NICE guidance (NICE CG 94 unstable angina and NSTEMI early management).

Relative risk of readmission

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital – elective admissions

From May 2017 to April 2018, patients at Birmingham Heartlands Hospital had a higher than expected risk of readmission for elective medical admissions compared to the England average.

Patients in gastroenterology, clinical haematology and clinical oncology had higher than expected risks of readmission for elective admissions.

Elective Admissions - Heartlands Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

Birmingham Heartlands Hospital - non-elective admissions

From May 2017 to April 2018, patients at Birmingham Heartlands Hospital had a higher than
expected risk of readmission for non-elective medical admissions compared to the England average.

Patients in general medicine, stroke medicine and cardiology had higher than expected risks of readmission for non-elective admissions.

Non-Elective Admissions - *Heartlands Hospital*

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Sentinel Stroke National Audit Programme (SSNAP)

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, August to November 2017. This was a drop from the previous A grade, which the trust has achieved in the previous four quarters.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C↓</td>
<td>B↑</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
</tbody>
</table>

Similarly, the trust scored an overall patient centred performance grade of B, which was a drop from the previous three quarters which had achieved an A. The only domain to drop in the most recent audit was specialist assessments, however the stroke unit and speech and language therapy domains have both been fairly consistent in scoring a C and are the lowest rated domains.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
</tbody>
</table>
The team centred performance was also awarded a B in the most recent audit, dropping from an A. Speech and language therapy was awarded a C grade, which is lower than the previous five audits. The stroke unit has achieved a C grade in five out of the last six audits.

<table>
<thead>
<tr>
<th>Team centred performance</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>A↑</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B↓</td>
<td>B</td>
<td>A↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>B</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C</td>
<td>B↑</td>
<td>A↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>D</td>
<td>C↑</td>
<td>B↑</td>
<td>C</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Team-centred total key indicator level</td>
<td>B↓</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London, SSNAP audit)

Lung Cancer Audit

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 64.7%, which did not meet the audit minimum standard of 90%. The 2016 figure was 61.4%.
The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.2%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 62.2%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 72.5%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one year relative survival rate for the trust in 2016 was 34.0%. This is within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

The 2017 National Audit of Inpatient Falls was carried out prior to the acquisition by acquisition of University Hospital Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust and has therefore not been included in this report.

(Source: Royal College of Physicians)

Prior to the trusts merging, Birmingham Heartlands Hospital had submitted data to the National Audit of Inpatient Falls which was reported in 2017. The results of this audit showed there were areas of poor performance. The audit used a red, amber and green (RAG) rating system to identify where hospitals were achieving standards. The hospital achieved a red rating for four of the standards:

- Delirium assessments were conducted in 10% of patients, compared to 40% for the national average.
- Visual assessments were not conducted in any of the patients, compare to 46% for the national average.
- Lying and standing blood pressures were conducted in 13% of patients, compared to 19% for the national average.
- Medication was reviewed for 15% of patients, compared to a national average of 48%.

The hospital met the standard for patients who had a call bell within their reach with a score of 83% and performed slightly better than the national average of 81%.

The standardised hospital mortality rate for Heartlands, Good Hope and Solihull hospital, for the period April 2017 to December 2017 was 92, the expected level is 100. There were 3,281 deaths compared with 3,554 expected. HGS’s HSMR for the period April 2017 to March 2018 was 102 which is within acceptable limits. There were 2,816 deaths compared with 2,755 expected. (PIR)

Competent staff

Appraisal rates
From April 2017 to March 2018, 89.1% of staff within medicine at the trust received an appraisal. This is below the trust target for Queen Elizabeth Hospital of 90% but above the target for other sites of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental staff</td>
<td>294</td>
<td>300</td>
<td>98.0%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>116</td>
<td>120</td>
<td>96.7%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>285</td>
<td>305</td>
<td>93.4%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>554</td>
<td>607</td>
<td>91.3%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>599</td>
<td>662</td>
<td>90.5%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>274</td>
<td>303</td>
<td>90.4%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>651</td>
<td>733</td>
<td>88.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>1,796</td>
<td>2,100</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

Birmingham Heartlands Hospital

From April 2017 to March 2018, 86.7% of staff within medicine at Birmingham Heartlands Hospital received an appraisal compared to a target of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental staff</td>
<td>75</td>
<td>77</td>
<td>97.4%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>113</td>
<td>122</td>
<td>92.6%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>451</td>
<td>490</td>
<td>92.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>114</td>
<td>127</td>
<td>89.8%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>226</td>
<td>260</td>
<td>86.9%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>76</td>
<td>89</td>
<td>85.4%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>557</td>
<td>695</td>
<td>80.1%</td>
</tr>
</tbody>
</table>

Qualified nursing and health visiting staff were the only staff group that failed to meet the target completion rate.

Staff we spoke with told us they had received an appraisal at some point, although could not accurately tell us how long ago this was. Most staff commented that appraisals were generally meaningful; however, training opportunities were not necessarily available due to staffing pressures, with some staff commenting on how even mandatory training sessions were cancelled due to pressures.

The senior team on AMU supported newly qualified nurses to complete a preceptorship and offered them supernumerary time when they first joined the unit. This was to ensure newly qualified nurses had the support needed to develop their competencies, which could be challenging in the demanding environment of this unit. A clinical nurse educator had been recruited to the hospital and was due to start later in 2018. This individual would provide dedicated support in the completion of mandatory training and support to newly qualified nurses.

There were arrangements in place for supporting and managing staff to deliver effective care and treatment. For example, on Ward 19, ‘training skills days’ took place to deliver training on caring
for a patient undergoing chemotherapy. Staff were also becoming competent in taking blood gas samples in order to ensure timely treatment for sepsis and other serious illnesses.

There were comprehensive competency packages for staff to complete on Wards 24 and 26 (Respiratory and Cystic Fibrosis Wards). These competency packages included non-invasive ventilation management, tracheostomy management, blood gas analysis, intravenous infusions, venepuncture and cannulation. There was a clinical educator who worked across both wards to ensure staff achieved the competencies. Senior staff from the ward told us how valuable this role was and how fortunate they were to have a member of staff who focused on providing education to ward based staff. The clinical educator was also an integral part of the preceptorship package which was available on the wards for newly qualified staff.

Staff from Ward 28 (infectious diseases and tropical medicine) had developed a competency package for staff working on the ward which included intravenous and venepuncture competencies, management of peripherally inserted central catheters (PICCs, which is a tube inserted into the arm or leg of a patient and the tip of the tube sits in the main vein of the heart), mask fit tested and train the trainer competencies, hood training and specimen/sampling techniques for high risk infections. Staff told us these competencies were essential to achieve for working on this ward to ensure staff safety was also maintained as well as patient safety. They were also exploring the possibility of developing an academic pathway for staff working in this area due to the reduction of courses available at universities.

Nursing staff on the acute stroke/hyper acute stroke ward (Ward 23) underwent competency training for swallowing assessments. This assessment was a fundamental requirement for patients who had suffered a stroke. Although this was a positive additional skill to acquire, staff told us there were difficulties for staff to get signed off with this competency when they rotated on to nights.

The service and hospital as a whole did not have a system for recording clinical supervision sessions which took place, however all staff employed with a professional qualification were supported to complete professional supervision with supervisors who were appropriately trained and experienced to undertake the role.

Staff had the skills, knowledge and experience to identify and manage issues arising from patients’ mental health conditions, learning disability, autism and dementia. All staff received training to identify mental health and learning disability issues as part of their mandatory training. Junior doctors had specific training in managing delirium (acute confusion) and medical staff, who did psychiatry as part of their rotation, had training in managing depression and psychosis.

Medical staff told us they were given the opportunity to attend organised training which was provided for them as well as receiving on the job training from their superiors. During our inspection, we observed a consultant ward round taking place and the consultant was dedicating a lot of that time to teaching the junior medical staff about pertinent points of their speciality they covered.

Pharmacists who covered the medical wards told us they were supported to develop their roles through additional training. Study days and short courses were provided and facilitated by senior pharmacists which were well received. Staff told us they found rotations through different specialities also supported their learning and development.

Volunteer staff worked across the medical wards and in other areas across the hospital site. The recruitment process and checks made on employment mirrored those of all other staff recruited to work at the hospital. Once recruited, volunteer staff complete mandatory training on food hygiene, infection prevention and control, safeguarding adults and children, fire safety, nutrition
and hydration, dementia awareness, health and safety, information governance and manual handling which was updated every two years. Volunteer staff were supervised on a local level wherever they were placed to work.

Poor or variable staff performance was identified and managed through informal one to one’s and appraisals with the staff member’s line manager. Staff described the appraisal process as a positive experience where they were able to discuss development opportunities and identify areas where they may require support to improve.

**Multidisciplinary working**

Throughout our inspection, by talking to staff, attending meetings and reviewing medical and nursing notes we found evidence of good multidisciplinary (MDT) working across teams. We saw that planning of care for patients started on admission to the ward, with input from the multidisciplinary team including doctors, nurses and allied healthcare professionals.

Medical notes and nursing notes were easily accessible within clinical areas when required. Ward based nursing staff were able to locate specific information within patient records. All members of the multidisciplinary team (MDT) documented in the same place. This meant all members of the MDT had access to all relevant notes.

Each ward we inspected had a twice daily handover review during the day shift. The afternoon handover was a short meeting of the nursing team on each ward to discuss new information and each patient’s care. We attended a MDT and observed staff discussing new patients and patients already known to them. The MDT was followed by a ward round; this was where the nursing and medical staff then reviewed each patient on the ward by seeing them in person.

We reviewed the medical records of patients who had complex needs and found evidence of MDT working and coordinated care. For example, we saw where different healthcare professionals and external agencies, for example local authority, had been involved in planning and implementing an appropriate care pathway.

Cancer Multi-Disciplinary Team (MDT) meetings were specifically arranged to ensure expert people come together to agree the best treatment for the patient. Heartlands hospital had a core membership for a cancer MDT and attendance for members was recorded. As part of the MDT process data entry of information to support both cancer waits and national audit requirements was undertaken. Each MDT had a lead clinician who was recognised as an expert in their field. There was consistent presence from physiotherapists, occupational therapists and dietitians on inpatient wards. However, staff described delays in obtaining reviews from the speech and language team (SALT).

**Seven-day services**

Prior to the trust acquisition this year, the hospital had participated in the seven-day clinical service survey under their former trust name of Heart of England. The results of the survey showed they were performing above the national standards for all four priority standards (seen by a consultant within 14 hours of admission, access to diagnostic tests, consultant directed interventions and daily ongoing consultant review). Access to diagnostic tests and consultant directed interventions achieved 100% compliance for all areas which the survey looked at (week day, weekend and overall seven-day provision). During our inspection we found patients still had access to diagnostic testing (imaging and pathology services) throughout the 24-hour period of care, seven days per week. We also saw evidence in the 23 notes we reviewed that all patients had received a consultant review within 14 hours of their admission into hospital.
There was a 24-hour service available for patients who required thrombolysis following a diagnosis of a stroke. This service was provided seven days a week, 365 days a year to ensure those who had suffered a stroke received the best care and treatment possible to enable them to recover. The stroke service also had access to speech and language therapists (SALT) seven days a week to support the patient treatment and rehabilitation pathway. All patients admitted with a suspected transient ischaemic attack (also known as a TIA or often called a “mini stroke”) had access to a TIA rapid access clinic, seven days a week.

The endoscopy service had started to provide a seven-day service due to the demand on services. They also provided an acute severe gastrointestinal (GI) complaints on-call rota which was consultant led (including those patients who were suffering a GI bleed). The staffing for the rota was shared with another location, however the procedures were conducted at this location. The endoscopy unit provided services seven days a week, from 8am to 7pm Monday to Friday and from 8am to 6pm at weekends.

Physiotherapy services were provided seven days a week and an on-call system was in operation if they were required out-of-hours.

Ward based pharmacists visited the wards Monday to Friday to review medication and a pharmacy on-call system was in operation at weekends and out of hours.

A dedicated, multidisciplinary discharge team were based in the AMU seven days a week with input from physiotherapy, occupational therapy and social workers. This team assisted the clinical ward team by coordinating complex discharge. They also worked to reduce barriers to discharge that could cause delays.

There was a psychiatric liaison team (RAID) available and an on-call psychiatrist available 24 hours a day, seven days a week for information and advice. Staff reported that this was a good service provided by the local mental health trust.

**Health promotion**

During our inspection, we saw few displays of information within the ward areas, including information around health promotion and the national priorities for a healthy nation. Staff told us they had been informed they would need to remove any displays on the walls due to standardising expectations across all sites. Prior to this, staff had various displays around the wards promoting specific health related topics related to the speciality of the ward. There was one area (frailty assessment unit) which we observed during our inspection which still had a limited display of health promotional resources which promoted healthy living and healthy lifestyles. A lot of these resources were targeted to the patients who attended for clinics which were also held in this area, however if these were relevant for patients who came through the department from a frailty assessment perspective, staff would use these resources to base health promotion conversations around.

Health promotion was usually provided on a one-to-one basis and individualised to the patients’ needs and staff would request additional input from specialist staff where required (for example dietitians, cancer nurse specialists, dementia specialist nurses, mental health nurses).

On the way into the hospital, there was a large display of health promotional resources for a variety of health topics including smoking cessation, healthy diets and living with cancer.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust combines safeguarding level 2, mental capacity and deprivation of liberty training.
A breakdown of compliance for mental capacity and deprivation of liberty safeguards training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding level 2 children and adults/deprivation of liberty safeguards and mental capacity</td>
<td></td>
<td>486</td>
<td>495</td>
<td>98.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for this training module.

A breakdown of compliance for mental capacity and deprivation of liberty safeguards training courses from April 2017 to March 2018 for medical staff in medicine at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding level 2 children and adults/deprivation of liberty safeguards and mental capacity</td>
<td></td>
<td>169</td>
<td>218</td>
<td>77.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this training module.

Staff we spoke with had variable knowledge of the MCA and identifying patients who may lack capacity, as well as best interest decisions and deprivation of liberty safeguards. Staff told us capacity assessments were usually completed by medical staff, mental health staff or occupational therapists sometimes completed them for therapy based decisions. Although nursing staff were able to complete a capacity assessment on a patient, most nursing staff did not feel confident enough to complete them. A member of staff from the safeguarding (adults) team often visited wards and would support staff when completing capacity assessments, however acknowledged that a lot of nursing staff were still reluctant to complete them.

Staff demonstrated to us their understanding and responsibilities in protecting the rights of patients subject to the Mental Health Act 1983 (MHA) and had regard to the MHA Code of Practice. This included, accessing internal and external support from mental health professionals when appropriate, acknowledging and managing challenging behaviour and applying diversion therapies to avoid actions such as restraint.

Staff had variable knowledge about the deprivation of liberty safeguards. Staff were generally aware of the requirements for when a patient was deprived of their liberty, however the
documentation around this was an area where staff were less aware. Senior staff we spoke with told us there was an area of weakness after an extension for an emergency deprivation of liberty safeguards had been requested due to the delay in best interest assessors reviewing the requests and granting approval. The documentation had moved to using the deprivation of liberty safeguard electronic portal for all applications. This online portal had given the trust a more assured process of current applications. When a deprivation of liberty safeguard was applied for within the trust on the portal the safeguarding team/ward were automatically notified through the secure generic email. These details were then entered onto a safeguarding database and a CQC notification sent. Staff on the wards told us they rarely chased these up a deprivation of liberty safeguards application once this had been completed, however they would liaise with their own safeguarding team on how to manage these patients, especially if there had been a significant amount of time since application.

During this inspection, we saw one patient who was deprived of their liberty. The Deprivation of Liberty Safeguard orders was completed correctly. The patient had been reviewed by the local authority safeguarding team and was due for a further review prior to discharge. However, during an afternoon visit to Ward 21 (Frailty Assessment Ward) the week following our initial inspection time, we found four patients who were deemed to lack capacity and were being deprived of their liberty with no official paperwork to support this. This therefore meant these patients were being unlawfully detained. We also found two of these patients had received chemical restraint with no supporting care plans in place for this use. This was escalated to the senior trust team at the time of inspection and immediate actions were taken to rectify this.

Staff on Ward 28 were knowledgeable about the requirements for making a request to hold a patient in relation to The Health Protection (Part 2A Orders) Regulations 2010. These powers are enforced against patients who are considered to be a risk to the health of the public due to highly contagious infections. Requests by the Local Authority are made to a Justice of the Peace to ‘detain’ a patient in hospital for isolation or quarantine purposes when a patient is deemed non-compliant and trying to leave before being suitably treated, and when all other options to ensure successful treatment have been exhausted. Senior staff told us they had been required to request for a patient to be held on a Part 2A Order previously and ensured a care plan to support the patients best interest was maintained for the duration of the detainment.

Patients and relatives we spoke with told us staff did not provide any care without first asking their permission. We observed staff asking for patient consent whenever they undertook an intervention. On checking patient records, we saw copies of signed consent forms and that in most cases consent to treatment was obtained appropriately. We did however find a consent form one which had been used to gain consent from a patient for a procedure despite concerns about the patients confused state and whether they had capacity documented during their admission. We raised this with the nurse in charge and the adult safeguarding nurse who was on the ward at the time and they would investigate this. We also saw a consent form four (a form used for the consenting of patients who lack capacity) was incorrectly completed in one patient record as this had been used for a patient who was not deemed to be lacking capacity and therefore had not received a capacity assessment.

The hospital used a ‘ReSPECT’ form (recommended summary plan for emergency care and treatment) to record patients wishes around end of life care and in particular their wishes around being resuscitated. These documents were introduced to enable better communication between healthcare staff and patients and their relatives about the dying process. We reviewed 13 ReSPECT forms which had been completed during the patient’s admission and found there was evidence on the form to indicate what the patient’s wishes were as they approached the end of
their life, however when it came to making decisions about whether or not to attempt resuscitation, we found there were still occasions when the discussions with the patient had not occurred. We found there were four forms which had no evidence of a discussion with the patient. Staff had indicated the reason for not discussing this was due to the patient lacking capacity to make the decision around resuscitation. Unfortunately, we could not find a capacity assessment in any of the four medical notes to support these decisions. The current legislation concerning DNACPR orders is Tracey verses Cambridgeshire NHS Foundation Hospital Trust, Addenbrookes: June 2014. This stated that NHS Trusts’ have a legal duty to consult with and inform patients if a DNACPR order is placed on their records. Non-discussion has been deemed as an infringement of a patient’s human rights and in particular denies them the ability to seek a second opinion if they disagree with a DNACPR decision’. This meant the trust was not adhering to the current legislation.

Is the service caring?

Compassionate care

We have included data from the pre-acquisition period for Queen Elizabeth Hospital in this analysis. Because it related to the same legal entity, University Hospitals Birmingham NHS Foundation Trust, we have used this to form part of our judgement. Data for Heart of England NHS Foundation Trust has only been included post-acquisition.

Birmingham Heartlands Hospital

The Friends and Family Test response rate for medicine at the Birmingham Heartlands Hospital was 28.9% from April to June 2018. A breakdown by ward is below (please note, only wards with at least 100 responses are shown).

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total responses</th>
<th>Response rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Apr-18</td>
</tr>
<tr>
<td>Ward 21 ECAU</td>
<td>151</td>
<td>129%</td>
<td>100%</td>
</tr>
<tr>
<td>AMU Assessment</td>
<td>176</td>
<td>28%</td>
<td>88%</td>
</tr>
<tr>
<td>HASU</td>
<td>117</td>
<td>50%</td>
<td>86%</td>
</tr>
<tr>
<td>Ward 4</td>
<td>155</td>
<td>40%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 6</td>
<td>195</td>
<td>39%</td>
<td>91%</td>
</tr>
<tr>
<td>Ward 22</td>
<td>167</td>
<td>36%</td>
<td>88%</td>
</tr>
<tr>
<td>Ward 28</td>
<td>118</td>
<td>34%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Ward 21 has a response rate of 129%, as 151 responses were received but only 117 patients recorded as eligible. If these numbers are reversed then the response rate is 77.5%.

On the whole, staff provided care with compassion and kindness. We observed good care on the wards and staff interacting with patients and relatives. Staff introduced themselves to patients when changing shifts. To gain a better understanding of patient experience we spoke with some patients and their relatives who told us staff were caring and compassionate towards them. We saw that staff engaged and interacted with patients and relatives in a kind and respectful manner and saw that patients and people close to them had given positive feedback shown on ward notice boards and cards displayed on the ward. However, we were informed of a negative experience on
one of the wards where staff had been ‘rude’ and ‘rough’ with a patient and had made them feel quite vulnerable. This was escalated to the nurse in charge and the trust’s most senior nursing team, who took immediate action.

All staff displayed compassion and understanding when discussing patients who had a cognitive impairment. They were respectful and empathic in their attitudes and actions.

During the inspection, we carried out a Short Observational Framework for Inspection (SOFI) on Ward 21. SOFI is a specific way of observing care to help us understand the experience of people who use the service, including those who are unable to talk with us. The evidence from the observations during this period showed staff were very quick to respond to patients’ needs and did so in a professional and caring manner. The interactions were all very positive between staff and patients, with staff demonstrating empathy, respect and warmth towards patients and reassuring those who required it.

Medical and nursing staff we spoke with demonstrated an understanding of patient care needs. Some wards provided consultant led ward rounds seven days a week in addition to access to specialist nurses and therapy services, depending on patient need.

Patients told us that they were offered pain relief regularly and that staff were prompt with administering medicines when patients were in pain. Patients spoke positively about the care they received as well as the staff providing that care. One patient told us “nothing is too much trouble; to be honest they could do with more nurses as they can be rushed off their feet but they always have a smile.” However, most patients felt the hospital would benefit from having more staff.

The Patient-Led Assessments of the Care Environment (PLACE) results from 2018 showed the inpatient wards achieved 73.3% for their privacy and dignity assessment which was below the England average of 84.2%. All the ward’s we inspected had individual bays with curtains provided for privacy and dignity. Some wards were in the process of adapting rooms in ward areas to patient/relatives rooms where they could discuss confidential matters in private. On the Frailty Assessment Unit, staff had access to moveable screens if staff needed to protect a patient’s privacy and dignity. However, we observed a patient dressed in night clothing which did not appear very dignified. Staff told us a lot of patients who were transferred to this area were still in their night clothes, they attempted to reduce the dignity issue through giving patients blankets to cover up with, although acknowledged this was far from ideal, this was the best they could do within the environment they were provided with.

We also found there were dignity concerns on two wards we visited which were experiencing significant staffing shortages at the time. On one ward we observed several call bells alarming due to patients requiring help with meeting activities of daily living (elimination needs) as well as patients who required other help and assistance. On another ward we found patients who had exposed themselves and had no access to their call bells. We raised this with staff on the wards at the time, and they tried to meet the needs of the patients as soon as they could, however all staff were with other patients at the time. Patient safety and dignity was an element which was reviewed as part of the ward matrix. An element of this assessment was to ensure all patients had access to their call bells. Information provided by the trust showed this requirement was met consistently between September 2017 and September 2018.

**Emotional support**

All wards within the service had open visiting times for relatives to visit and support patients. Staff told us they actively encouraged relatives to visit at all times of the day when they knew patients
required additional emotional support. We observed one member of staff who was discussing treatment options with a patient who offered to call in a patient’s family to be with them whilst they discussed this important information. We also saw other staff members offering patients the opportunity for them to return at a later time when they knew their relatives would be available.

The service had clinical nurse specialists/specialist teams available to provide patients with additional support and advice if required. Examples of most commonly used specialists to provide emotional support to patients were the dementia and delirium outreach team (DADOT), the enhanced care team and the palliative care team.

There was psychological support for patients on the cystic fibrosis ward. Although this was mainly provided for patients who required additional support, they were also available to provide support to relatives of cystic fibrosis patients. There were also a team of specialist nurses who were also available to provide emotional support for patients whilst admitted in the hospital, but also in the community when discharged home.

The hospital had a multi-faith and inter-denominational chaplaincy department who were available to provide emotional and spiritual support to patients who required this. Members of the Christian and Muslim faiths were available through an on-call system 24 hours a day, however additional faith leaders could be accessed if required (Jewish, Sikh, Hindu and Buddhist religions).

Understanding and involvement of patients and those close to them

During our inspection we spoke with 15 patients about whether they felt involved and understood about their care. They told us they felt very involved with their care and treatment choices and had a good understanding of their condition and the treatment plan devised for them by their medical team.

We saw all staff taking time to clarify patients’ understanding of their care and treatment. In one observation, we saw a member of the medical staff discussing the patient’s diagnosis with them in a kind and respectful way, but also in a way which was not rushed and gave the patient the opportunity to ask questions. In another observation, we saw staff members discussing with a patient and their relatives about the progress they had made in their recovery from an illness. Again, this was done in a way which was appropriate to the patient’s level of understanding (although at the same time, not patronising) and gave both the patient and their relatives the opportunity to clarify anything they had not understood and ask further questions about anything.

We also observed medical and nursing staff arranging times with patients and their relatives for an ideal opportunity to discuss the treatment and care plan in place for the patient and the plan going forward, this ensured they would be able to have a meaningful discussion which would involve all those involved in the patient’s holistic plan of care. This was also supported by comments made by the patients we spoke with. If patients had not understood fully what was going on with their care and treatment, patients and their relatives were confident to ask staff questions.

We observed staff involving the patient and their family/carers in discharge planning to ensure the patient was discharged in a safe and dignified manner. This included arranging times with the carer so they would be available to meet them at their discharge destination, and bringing in appropriate clothing for the patient to be discharged home in.

Is the service responsive?

Service delivery to meet the needs of local people
University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital

From March 2017 to February 2018 the average length of stay for medical elective patients at Birmingham Heartlands Hospital was 4.9 days, which was shorter than the England average of 6.0 days.

Average lengths of stay for elective specialties:

- Average lengths of stay for elective patients in cardiology and the adult cystic fibrosis service were shorter than the England averages
- Average length of stay for elective patients in respiratory physiology was similar to the England average

**Elective Average Length of Stay - Heartlands Hospital**

Over the same period, for medical non-elective patients, the average length of stay was 5.3 days, which was shorter than the England average of 6.4 days.

Average lengths of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine, stroke medicine and cardiology were shorter than the England average

**Non-Elective Average Length of Stay – Birmingham Heartlands Hospital**
All wards monitored their average length of stay using the electronic system used for monitoring multidisciplinary input and discharge planning board. Each ward had an average length of stay identified, however at the time of our inspection due to admission pressures, staff told us on most wards they were over this. Staff from most wards told us their average length of stay was currently between seven and 11 days, however in some wards they had patients who had been admitted for over 100 days. There were many reasons given for extended stay in hospital and more specifically on wards with an expected low average length of stay, this included patients requiring isolation, change in dependency for a ward and patients waiting for social care packages to be arranged/started.

The trust engaged with internal and external stakeholders including patients, governors, members, partners and staff to plan services. For example, the trust engaged patients and members of the community to join locality forums to help shape the future of the services provided. Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally.

In planning services, the medical leads appointed a number of specialist nurses and clinical educators across the site to support ward provision and to meet the needs of patients requiring specialist care. For example, in cancer care - consultant clinical psychologists, clinical nurse specialists and chemotherapy nurses. The trust also employed specialist nurses for haematology, lung and upper gastrointestinal / hepatobiliary and a cancer of unknown primary team.

The hospital provided patient focused services where patients could attend and be treated without the need for an overnight stay in hospital. For example, a ‘one-stop’ transient ischaemic attack (TIA) clinic.

The trust also provided a frailty ward, which aimed to prevent avoidable admissions to hospital by urgently arranging home support through community links. The team included a physiotherapists, occupational therapists, social workers and nurses.

Wards included single-gender accommodation. From April 2017 to March 2018, the hospital reported four occasions where a breach had occurred, which were all reported on the Hyper Acute Stroke Ward (Ward 23). However, we noted during our inspection of the frailty assessment unit that male and female patients were all seated together in the area. We observed patients who were undergoing treatment in this area and a patient who was seated in their night clothes as they were brought into hospital in the early hours of the morning. This had the potential for affecting the patients’ privacy and dignity. We reviewed the standard operating procedure (SOP) for this area to see if this had been taken into consideration, however there was no acknowledgement of potential privacy and dignity issues.
Respiratory and Infectious Diseases consultants had identified a higher incidence of patients with non-tuberculosis mycobacterium (NTM) infections in the local area. Specialist clinics were implemented one year ago to meet the needs of this population and had found them to be beneficial.

**Meeting people’s individual needs**

Arrangements were in place for patients who needed interpreting services. Staff had access to an external interpreting service, 24 hours a day, seven days a week. Staff told us they were also able to access other staff within the hospital who spoke additional languages. During our inspection, we saw leaflets and posters mostly provided in English. However, they did indicate (in an alternative language) that leaflets could be translated if required.

Staff told us they had access to British Sign Language interpreters for patients who required this. In addition to this, on some of the wards we visited, staff had completed courses in sign language and Makaton. At the time of our inspection, we observed staff using these forms of communication with a patient who was profoundly deaf.

A dedicated team of volunteers provided individual support for patients on wards. This team were competency-assessed using a structured checklist and had supervision from a volunteer manager. This ensured they could deliver support to patients within established boundaries and with a good understanding of health and safety policies and principles.

All emergency admissions of patients over 75 years were screened for dementia as part of the admission process.

The trust told us the admission of a patient living with dementia being admitted would trigger the use of the ‘This is Me’ document. However, we reviewed five patients with a diagnosis of dementia. This is me documents were not available at the point of care for none of them.

Ward environments at Heartlands Hospital had not been upgraded to make them dementia friendly with ‘dementia friendly’ signs, quiet rooms, retreat rooms or reminiscence boxes. The trust advertised on its website the use of a communication box. These communication boxes were supposed to be available on all wards/departments and were to be used in an emergency situation, to enable a patient to communicate effectively with staff until a relative could bring in items they need (e.g. hearing aid, spectacles, etc.). We saw a communication box on one ward there were only three of the seven items in the box. Staff could not identify where the other items were. We could not be assured that the boxes were available or used effectively throughout the hospital.

The trust also advertised the use of hearing aid pink storage boxes to reduce the risk of loss of the hearing aid. We were not told of these during our inspection during discussions with ward staff about care of patients living with dementia. The trust website also mentioned the use of Reminiscence Interactive Therapy Activities (RITA). This was an all in one touch screen computer that allowed patients living dementia or cognitive impairment to:

- Watch movie clips or old TV programs
- Play interactive games
- Run reminiscence sessions or triggers to promote conversations
- Monitor the persons mood and wellbeing
- Helps carers and family members communicate more effectively with the patient
- Offers armchair or group exercises to help with overall health and wellbeing
• Creation of life story books which can be used to engage the person, especially during enhanced care
• Listen to a variety of different genres of music
• Watch regional media content for twelve UK regions

However, we were not told about this equipment and did not see it during our inspection.

All ward areas had bathroom and toilet signage in order that patients living with dementia could assist themselves to the toilet where appropriate. Wheelchair access was good throughout the hospital. Disabled toilets were located at frequent intervals and were clearly signposted.

The most recent result from the Patient-Led Assessments of the Care Environment (PLACE) from 2018 relating to dementia was 64.2% which was above the national average of 78.9%. The assessment for how facilities meet this requirement mainly looked at how the environment met the requirements of a patient living with dementia (signage, décor and flooring) although it also took into account the seating and assistance products (such as hand rails) for patients to use.

The most recent results from the PLACE 2018 assessment relating to disability was 70.9% which was above the national average of 84.2%. This assessment mainly focused on how the environment was suitable to patients with a disability, including wheelchair access, signage and additional aids to help with mobility including hand rails. This also took into account whether the environment had hearing loop facilities for patients with a hearing impairment.

The trust had a Dementia and Delirium Outreach Team (DADOT), training for dementia care was provided by them. The DADOT would review patients on the wards on request and the enhanced care team would provide 1:1 support to patients, relatives/carers and staff.

Staff we spoke with explained adjustments which could be made for patients; environmental (moving patients to a quieter side room) and treatment (offering first/ last or double appointments). The trust had a patient care pathway for adult patients living with a Learning Disability.

The patient care pathway included specific guidance for a variety of care settings across the sites and included safeguarding, discharge planning and referral to the learning disability liaison teams. A Learning Disability webpage on the trust intranet guided staff in accessing the Learning Disability Acute Liaison Nurse teams service and links were provided to the Learning Disability Toolkit; My Hospital Book and accessible information and leaflets. However, nursing staff we spoke with told us the trust had no flagging system to identify when patients living with a learning disability were admitted.

The hospital did not have a specific care pathway or policy for people with Autism.

We spoke with medical and nursing staff in relation to patients requiring mental health support whilst an inpatient or as an emergency. All staff were aware of the psychiatry contact numbers for assessment. However, staff did not seem to consider specific mental health problems, but more general emotional wellbeing. Staff were also unsure when asked what they would do if they could not get assistance from the liaison team, as they had little specific mental health training.

There was a website specifically aimed at patients with cystic fibrosis which provided them with all the information they needed to know about the service provided at the hospital.

**Access and flow**

University Hospitals Birmingham NHS Foundation Trust
We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.

![Chart showing RTT rates for University Hospitals Birmingham NHS Foundation Trust compared to England average.]

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.

![Chart showing RTT rates for Heart of England NHS Foundation Trust compared to England average.]

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to July 2018.
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>97.1%</td>
</tr>
<tr>
<td>General medicine</td>
<td>99.6%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>98.8%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.4%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>92.9%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>92.4%</td>
<td>91.0%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>93.4%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.0%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Four specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>99.5%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.9%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>95.0%</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>94.1%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>69.6%</td>
<td>81.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Patient moving wards per admission**

From April 2017 to March 2018 the trust did not report any patient moves for non-clinical reasons in medicine.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Patient moving wards at night**

The trust reported the ward moves at night data separately for all sites.
From July 2017 to June 2018, there were 1,166 patient moving wards at night within medicine.

The wards with the highest number of ward moves at night were:
- Short Stay with 237 moves (20.3%)
- Frailty Assessment Unit with 188 moves (16.1%)
- Ward 7 - Short stay acute medicine with 144 moves (12.3%)

During the period of April 2017 to March 2018, there were 13,240 discharges across the whole of the medicine service. Of these, 689 were recorded by the hospital as delayed discharges. The two wards which recorded the largest number of delayed discharges were Ward 29 and 30, both of which were elderly care wards. This coincided with what we found during our inspection with heightened average length of stays.

Staff in each specialty and service area used three times daily bed meetings to coordinate flow across the trust’s services. We did not attend a bed meeting but were told it was attended by the wider multidisciplinary and divisional teams with a focus on timely and safe discharge. This meeting process enabled teams to speed up communication with community services, including social care, to facilitate more complex discharge cases.

Staff told us medical outliers was unusual across the site. During our inspection, there were four patients who were admitted into a non-medical ward bed. All patients were reviewed under their speciality team and were not disadvantaged by being on a non-medical ward. The regular bed meetings observed the number of outliers and their location, with staff attempting to repatriate them to the correct ward once clinically appropriate and a bed was available.

At the time of our inspection, there were no escalation wards/beds open within the hospital, however the hospital management exercised the safer patient placing policy. This was implemented when the Emergency Department (ED) and Acute Medicine Unit (AMU) was experiencing high volumes of admissions. This enabled these areas to send a patient to the ward where a discharge was expected. Senior management staff for the hospital told us this was only completed during times of high activity and they would not do this if there were known staffing issues on the wards. However, ward staff told us this had become a regular occurrence and was not dependant on escalation processes due to high activity. Staff on some wards told us they were sometimes asked to identify the night before if they would have a male or female vacancy the next day to allow the process to occur early in the morning. We were also told by ward staff of all levels this process would occur regardless of whether they ward were well staffed or not. As well as the safety issues which were already identified in this report, staff told us this had been problematic on occasions due to patients not being discharged as originally expected (either delayed for a period of hours or discharged cancelled for that day) resulting in flow and capacity issues on the ward.

There were arrangements in place for patients, with mental health needs, to be seen by an appropriate mental health clinician. Staff had access to mental health liaison and/or other specialist mental health support if they were concerned about risks associated with a patient’s mental health. Nursing and medical staff described “good links” with the older person’s mental health team, the local mental health trust and the frail older person’s advice and liaison team.

Staff on wards we visited told us there was no specific discharge co-ordinator, this impacted on discharges as the shift co-ordinator was usually providing patient care and unable to expediate discharges in a timely manner.
As part of our inspection, we visited the Discharge Lounge. The Discharge Lounge provided a service for patients being discharged at ward level. The concept of the Discharge Lounge was to free up acute hospital beds as early as possible on a daily basis, thus reducing the length of time both emergency and elective admissions had to wait for a bed to become available. Staff told us the discharge lounge had recently moved into a different location (near the staff education centre) and this had an impact on the patients who could be moved from the ward when they were awaiting discharge. Patients who were a falls risk, confused or bed bound were no longer able to move to the discharge lounge and this had impacted on the flow of the wards.

There were rapid access clinics for patients with symptoms of a transient ischaemic attack (TIA) as well as renal patients who were experiencing problems with their fistula used in dialysis treatment (connecting a vein and artery together for haemodialysis treatment).

As a result of recent expansion in oncology services across the other trust sites access to chemotherapy rapid access clinics had improved. This ensured patients were receiving their subsequent chemotherapy and supportive treatment regimens in a timely way.

**Learning from complaints and concerns**

**Summary of complaints**

**Trust level**

From April 2017 to March 2018 there were 201 complaints about medical care across the trust as a whole. The trust took an average of 42 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Of the 25 complaints still open at the time of reporting all had been open longer than the trust target of 30 working days, the longest being open for 231 working days.

A breakdown by site is below:

- Queen Elizabeth Hospital: There were 104 complaints, the main themes were patient care with 30 complaints (28.8%), clinical treatment with 20 complaints (19.2%), communications with 18 complaints (17.3%) and admissions, discharges and transfers with 13 complaints (12.5%)
- Birmingham Heartlands Hospital: There were 48 complaints, the main themes were all aspects of clinical treatment with 28 complaints (58.3%) and admissions, discharge and transfer arrangements with 11 complaints (22.9%)
- Good Hope Hospital: There were 35 complaints, the main themes were all aspects of clinical treatment with 16 complaints (45.7%), communication/information to patients with five complaints (14.3%) and admissions, discharge and transfer arrangements with four complaints (11.4%)
- Solihull Hospital: There were 14 complaints, the main theme was all aspects of clinical treatment with eight complaints (57.1%)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 727 compliments within medicine.
The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>689</td>
<td>94.8%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>20</td>
<td>2.8%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>9</td>
<td>1.2%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>7</td>
<td>1.0%</td>
</tr>
<tr>
<td>Birmingham Chest Clinic</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Morris House</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>727</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The trust had an up-to-date complaints policy. The policy was available for staff to access on the staff intranet. The policy and procedure provided guidance and standards for the handling of complaints.

All complaints were 'triaged' by the divisional heads of nursing to determine who should lead the investigation based on the content of the complaint. There was a dedicated complaints officer who managed the complaints for each division. They liaised closely with divisional colleagues by phone, email and in person to secure reports, draft responses and arrange meetings. The investigation was documented in the information sent from the division to the complaints officer. Progress with the investigation was also recorded on a database and regular reports could be produced from this information. The response was drafted by the relevant complaints officer, sent to the contributors for review and confirmation of clinical content and the senior divisional triumvirate for divisional sign off. It was then further reviewed by the head nurse for patient experience / senior member of the corporate nursing management team before going to the director of nursing for final review and sign off on behalf of the chief executive.

Responses to complaints included any learning from the complaints investigation. Complaints and responses were shared with ward and department staff at team meetings. A quarterly report of all actions was sent to each division to enable them to provide assurance that the actions had been implemented. Individual actions from complaints were captured on a database. During our inspection we were informed about several examples of complaints where wards had implemented learning as a result from them. Complaints were discussed as part of regular ward meetings and this was where important information and learning was cascaded to the rest of the team. Staff we spoke with told us if a patient or relative had concerns about care being delivered they would try to address the issue at the time in order to resolve the concerns as quickly as possible.

During our inspection, we only observed one ward (Ward 3 Renal Medicine) which displayed information about the complaints procedure which patients and their relatives should follow if they had concerns. Information provided by the trust prior to our inspection informed us leaflets entitled 'your stay in hospital' were available in all wards and departments for patients who required them, however we did not see these leaflets. Patients and relatives we spoke with told us they felt comfortable in raising concerns with the ward staff if they had any complaints. Complaints information was also provided on the hospital’s internet webpage.
Is the service well-led?

Leadership

University Hospitals of Birmingham NHS Trust provided medical services as part of the Heartlands, Solihull and Good Hope (HSG) Division 3. Leadership of Division 3 was provided by the divisional director, divisional head of nursing, divisional director of operations and divisional finance manager. Divisional leads were supported by deputies and matrons.

Without exception, leaders demonstrated to us they had the skills, knowledge, experience and integrity required to undertake their roles and all had an understanding of, and were extremely focussed on, the challenges within their services. Challenges identified by the leadership team reflected the concerns we had identified during this inspection.

During this inspection, the majority of ward staff knew the chief executive and the chief nurse either from meeting them or from information shared through e-mails. Junior doctors told us they felt generally well supported during the day time, however during the nights the medicine service experienced significant short notice staff sickness/staff not turning up which impacted on the availability of senior support. Consultants were well regarded by all levels of doctors, however the demands on the service had meant junior doctors did not always received protected time in the clinics with the consultants to enable their development.

Most staff we spoke with that had not met the leadership team and did not feel they saw the divisional team leaders enough.

There was a mixed response from front line staff about the leadership across the organisation including, from their line managers and matrons of the service. Most nursing staff were complimentary about their ward leaders and felt they were highly visible and supportive, however not all staff on the wards were as complimentary about the leadership provided by the matrons.

Some staff had commented on how they rarely saw the matron responsible for their areas due to the numerous areas of responsibility which they had to cover, including across other sites. In some areas where there were large vacancies and high demand, even when matrons had been on site, staff had commented on how they would not attend the ward to aid the nursing team. During our inspection, we did not routinely observe matrons' and heads of nursing out in the clinical areas.

The trust had an appointed ‘Freedom to Speak Up Guardian’. All staff, both medical and nursing, were aware of the trust ‘Freedom to Speak Up / Raising Concerns’ (Whistleblowing) policy. However, not all staff could recall what the freedom to speak up guardian did. There was a mixed response from staff we spoke with about speaking up in the organisation. Some staff said they would feel confident about raising concerns and speaking with their manager if they had a problem or concern, however there were staff around the medicine service who had no confidence in raising concerns, mainly because they felt no action would be taken. No members of staff told us they would not raise a concern due to fear of reprisals by senior managers. Some staff had used the freedom to speak up guardian during our inspection and told us they felt listened to and felt empowered to raise concerns.

There was no designated lead for mental health identified within the medicine service.

Vision and strategy

The vision of this hospital was to build healthier lives. There were underpinning values to achieve this vision which staff were aware of.

- Collaborative

Working in partnership with others to provide safe, appropriate care and improve outcomes.
Honest
Being transparent in all that we do, communicating openly, inclusively and with integrity.

Accountable
Taking personal and collective responsibility for the way in which we deliver care.

Innovative
Being responsive, creative and flexible, always looking for ways to do things better.

Respectful
Treating everyone with compassion, dignity and professionalism.

The values and standards were displayed around all of the wards we visited, as well as other none clinical areas to ensure all staff were aware of them. Staff were also invited to attend workshops around embedding the vision and values within the hospital site, however none of the members of staff we spoke with mentioned attending these workshops.

Culture
Ward based staff we spoke with showed a positive attitude towards caring for patients, families and carers. However, most of the staff we spoke with told us morale on the ward was considerably lower than it had been for a long time due to staff shortages. This had been impacted further by the changes made to the bank payment arrangements which staff were not informed about prior to its implementation.

We found an open, honest and supportive culture with staff engaged, open to new ideas and interested in sharing best practice. There were numerous opportunities for staff to receive formal training around the duty of candour and the importance of openness, transparency and honesty.

Staff, on the whole, reported positive working relationships, and we observed staff were respectful towards each other across all disciplines. However, there were some staff who told us due to pressures from the staffing levels, it had made staff relationships volatile at times. An example we were given was around new members of staff who had not completed all competency skills. Although staff they were working with appreciated it took time to achieve the competencies, staff members felt they were made to feel guilty for asking other staff members to do some of their tasks.

Staff said they had regular opportunities to raise and discuss concerns, and some staff had used this opportunity to voice their concerns. However, there were a number of staff across the service who told us they had stopped raising concerns as nothing appeared to be done about the concerns they raised.

There was a mixed response from ward staff about communication within their teams and with their senior colleagues. Staff on some wards had established secure, restricted-access social media communication groups to enable them to stay up to date with changes and new policies. This meant staff could stay up to date even if they could not attend staff meetings. However, communication about relevant and important issues from managers above their immediate line managers was not consistent within the service. About half of the staff we spoke with had positive experiences with communicating with their matrons, however the remaining half did not see their matron very often and did not receive any communication from them.

The trust had processes in place to ensure equality and diversity was promoted within and beyond the organisation. During our inspection, no staff members voiced concerns over the way in which they were treated from an equality and diversity perspective.
Governance

There was evidence of clinical governance procedures and quality measurement processes in the medicine division. It was evident that risks were identified and escalated through different committees. Monthly medicine division clinical governance meetings were held which were well attended. We reviewed the papers and minutes, which showed that agenda items included items such as the risk register, clinical audits, incidents, serious incidents, patient experience and mortality were discussed.

Most teams met regularly and relevant information on quality and performance was communicated to the trust board through the clinical director ensuring effective ‘ward to board’ communication. Some staff told us ward meetings had reduced recently due to the pressures on the ward and sickness of senior staff.

The trust had a contractual agreement in place with a neighbouring NHS trust with specialist expertise in the care of patients living with a mental health concern. This helped support the trust to ensure they met their obligations under the Mental Health Act and Mental Health Act Code of Practice.

All service level agreements (SLAs) which impacted on the medical provision at this site were managed at trust level.

Sepsis management and performance was reported to the board by the chief nurse and director of infection prevention and control. As there were no staff members designated to monitoring compliance with sepsis identification and management, local management and monitoring of sepsis was the responsibility of ward staff including the medical teams.

Management of risk, issues and performance

All staff on all wards we visited during our inspection told us the safer patient/placing protocol which was instigated to try and reduce the pressures on ED and the acute medical unit was a significant risk to them. Senior staff told us they were appreciative of the challenges in the emergency areas, however the risk was transferred to them and at times of already significant challenge to them (staffing issues and higher acuity) this was deemed as a high risk. However, all wards told us this had not been entered on to their local risk register.

The medicine divisional risk register main risks included the nursing workforce vacancies, medical workforce vacancies, electronic prescriptions, IT systems, chemotherapy prescriptions, machines for dialysis and delayed transfers of care.

Locally, senior staff monitored key governance indicators on a monthly basis through the use of a ward matrix. Key indicators were rated as either achieved (coloured green) or not achieved (coloured red). The compliance standard for achieving each element was 95%. Areas which were regularly assessed were environment, resuscitation trolleys, patient safety and dignity, observations, fluid balance, tissue viability, nutritional assessments, falls assessments, manual handling, continence assessments and blood glucose monitoring. All key indicators had individual elements which were assessed for compliance and overall compliance assessed from this. Information provided by the trust showed most elements had an overall compliance rate of above 95%, however areas which were currently not compliant were fluid balance monitoring, nutritional assessments and blood glucose monitoring. Senior staff were aware of areas which required more attention and were working locally with their staff to improve the results.

Antimicrobial stewardship was monitored at trust level; however, staff were all aware of their roles and responsibilities in regards to the prescribing and administration of antimicrobials. A robust framework was in place to ensure rapid and accurate diagnostics and surveillance occurred as
well as ward reviews by members of the infection prevention and antimicrobial specialists. Regular antimicrobial audits were conducted and reported to the board.

The management of mentally unwell patients was seen as the responsibility of the rapid, assessment, interface and discharge (RAID) team once staff had identified the input of specialist were required and referral made to them. Staff were unaware of any audits being conducted in relation to patients mental health and emotional well-being.

National Safety Standards for Invasive Procedures (NatSSIPS) were created to bring together national and local learning from the analysis of never events, serious incidents and near misses in a set of recommendations that will help NHS organisations to provide safer care to their patients. Local Safety Standards for Invasive Procedures (LocSSIPS) were produced locally in the endoscopy unit and the cardiology department.

The medical services had identified the requirement for preparedness for influenza cases this year. During our inspection, we observed staff attending ward areas as part of this campaign to vaccinate staff at work. Staff completing the vaccinating told us the campaign had so far been very successful even though it had only recently started.

**Information management**

Senior managers, including ward leaders demonstrated to us they had a good understanding of performance across the medical areas and gave examples of how clinical audit, performance scorecards and patient and staff feedback were used to drive improvements across the service. They told us that they had access to the information they needed to monitor performance to ensure there was a sustained or improvement to standards of care. Information included performance in relation to quality as well as finance.

Leaders had information including performance dashboards, staffing figures, complaints and patient feedback and used this information to understand and respond to issues in the hospital.

Important information such as safety notices and key messages were displayed on notice boards in staff areas to help keep staff up to date. Staff also had key messages sent to them through email, however staff told us they did not always have the time to access their emails so relied on other forms of notification.

Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible through the trusts intranet facility. There was sufficient access to computers and handheld devices on the wards. Staff had access to the patient records and diagnostic tests that they needed, when they needed it.

Arrangements to ensure the confidentiality of identifiable data were not always robust. Across all medical wards we saw medical notes were not always secured by a key code lock or stored in a secure room. However, computers were not left logged on or visible.

Mental health records including care plans and assessments were not held on the trust patient admission system, but on the local mental health trusts patient record system. At the time of the inspection, the systems were not linked in anyway so staff were unable to observe what mental health records were held for their patients. Staff did tell us, if their patients had been seen by a member of the local mental health team, there would be an indication on the patient admission system and the team would write an entry into the patient medical notes, but this may not be as detailed as the notes on the mental health trusts patient record system.

**Engagement**
We spoke with 52 staff from a variety of roles. There was mixed feedback from staff about their engagement with their positions. All staff without exception told us they were passionate about their position within healthcare and caring for patients, however staff were struggling with the pressures experienced within some of the wards and departments. Not all staff felt able to raise concerns or felt empowered to suggest new ways of working within their areas because they felt they would not be listened to. Information from the trusts 2017 staff survey showed they had performed within the top 20% of all trusts for appraisal performance and had achieved their highest results for recommending their place of work for receiving care and treatment. However, there were three areas where the trust had identified a particular weakness, this was for recognition and valued by managers and organisation, good communication between senior management and staff and support from immediate line manager. Staff well-being had also been identified as an area of concern from the staff survey. In response to the staff survey, senior management were working on a four point strategy to improve staff satisfaction. The four main points of this focused on staff well-being, staff recognition, leadership and flexible working.

Prior to this inspection, the trust had undergone an acquisition process to become the University of Hospitals Birmingham. Since this had occurred, staff told us they had seen new information displayed with the executives on them, however the majority of staff had not met the chief executive or the chief nurse. However, they were aware of information which had been shared with them which had come from the executive team and occasionally they received updates directly from them through e-mails. Medical staff told us they mainly felt supported during the daytime, however they had experienced shortages of senior members of staff during night shifts which had impacted on the support available to them.

Patient feedback was generally obtained through the NHS Friends and Family test (FFT). In addition, the wards we visited displayed ‘thank you cards’ from patients and members of the public. The trust did have a ‘patient community panel’ in place which they consulted for key proposals and developments at the hospital. Examples of issues which the panel were consulted about included dementia awareness training and the acquisition between the old Heart of England trust and Queen Elizabeth Hospital Birmingham.

**Learning, continuous improvement and innovation**

Senior leaders were engaged and demonstrated passion for the services being delivered, they were excited about the improvements that had been made but equally remained cited on the challenges they still faced. Whilst staffing remained a significant challenge across the trust, ward staff were patient focussed and showed determination to deliver safe care.

All adult deaths within medical care services were discussed to identify any possibility of learning; cases were referred to the relevant speciality for discussion at the specialty mortality and morbidity meetings to confirm and share learning and agree actions, as applicable.

Senior staff recognised the need for future sustainability of the workforce and provided development opportunities for staff nurses to progress to roles that are more senior. This included secondments to senior posts as part of professional development plans.

Advanced nurse practitioners (ANPs) were in post in the AMU and on Wards 19 and 24. Additional nurse training and education had enabled ANPs to carry out patient consultations and physical examinations, develop a differential diagnosis and prescribe where appropriate. We spoke with three ANPs, they were all very supportive of each other and aware of the development of the role in order to support both the medical and nursing teams. The nursing team on Ward 19 explained the benefit of having an ANP available, always having someone with clinical expertise around providing continuity for the patients and the medical staff. The team were
expanding in order to provide further services. For example:

- ACP led Portacath insertion service
- Community stem cell transplant service
- Ambulatory acute oncology service
- Paracentesis
- Pleural drainage
- Management of Low Risk Febrile Neutropenia

The creation of day chemotherapy regimens to be undertaken on the day unit on Ward 19 this released ward bed capacity (around one bed per day) and enhanced patient experience and flow. Planned to allow the development of a designated young patient area within the unit. As a result of the current developments in Oncology and Haematology across the trust the re-modelling of Ward 19 Day Unit will provide high risk chemotherapy and a procedures environment that will facilitate expansion of Community Bone Marrow Transplant (BMT) provision in a dedicated environment supporting the teams vision for community based care by having designated capacity within Ward 19 Day Unit for outpatient autologous stem cell transplants. Currently this provision is predominantly ward based with extend length of stays of up to 3 weeks. This work had enabled the directorate to develop its Acute Oncology Service (AOS) further with the development of an AOS assessment area on Ward 19 Day Unit to allow the management of acute oncology patients outside of Emergency Department (ED) and Acute Medical Unit (AMU). The current Ward 19 based triage provision will also be able to link into this development; this provision currently picks up post chemotherapy patients by bringing them directly to the ward rather than going through ED and AMU. Both provisions being based in this legacy space will ultimately result in reduction of LOS, better patient care and overall health cost benefits and admission avoidance.

The oncology and haematology teams were extremely proud of the developments that were in progress in developing a designated chemotherapy unit and making Ward 19 Day Unit a safer environment this would in turn support the retention and recruitment of high quality nursing staff as the Trust’s Haematology and Oncology Service will be become a more appealing place for staff to work and develop.

A ward personal assistant role had been established. This team assisted in the performance and governance of each ward through audit administration support and arranging staff rotas to ensure they had time for mandatory training updates.

Staff on various units had established secure, private social media groups to improve communication between them.

Staff on Ward 24 had completed a documentation initiative to improve the quality of documentation in patient notes. This had been in response to a complaint raised about patient care on the ward, however when investigating the complaint, staff deemed it difficult to provide a full time line of events due to the quality of documentation by staff. The ‘POINTS’ system was developed to standardise documentation for staff who cared for a patient during a specific period of time.
Surgical services at the University Hospitals Birmingham NHS Foundation Trust are provided at the Queen Elizabeth hospital, Good Hope hospital, Heartlands hospital and Solihull hospital. This evidence appendix focuses on surgical services provided at Birmingham Heartlands hospital (referred to throughout the report as Heartlands hospital). Surgical services at the other sites are reported in separate evidence appendices. However, as the management team also have responsibility for services at Good Hope hospital and Solihull hospital and some staff also provide care and treatment at these sites, there is inevitably some elements of the report that are the same across each of the three sites.

Heartlands hospital has seven surgical wards (listed below), a day surgery unit, pre-assessment clinic along with operating theatres and recovery areas.

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

A site breakdown can be found below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>Ward 14</td>
<td>Elective orthopaedics and trauma</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 15</td>
<td>Elective orthopaedics and trauma</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 16</td>
<td>Elective/emergency colorectal surgery</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 17 SAU</td>
<td>Surgery assessment unit/general surgery</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td><strong>Total beds</strong></td>
<td></td>
<td><strong>108</strong></td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>Ward 4</td>
<td>Elective/emergency thoracic and vascular surgery</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Ward 5</td>
<td>Elective/emergency ENT/general surgery</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Ward 8</td>
<td>Acute trauma and rehabilitation</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Ward 9</td>
<td>Acute trauma and rehabilitation</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Ward 10</td>
<td>Elective/emergency urology and urology treatment centre</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Ward 11 SAU</td>
<td>Surgery assessment unit/general surgery</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Ward 12</td>
<td>Elective/emergency colorectal surgery</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td><strong>Total beds</strong></td>
<td></td>
<td><strong>207</strong></td>
</tr>
<tr>
<td>Queen Elizabeth Hospital Birmingham</td>
<td>Admissions lounge</td>
<td>Elective surgical admissions</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Ambulatory care services</td>
<td>Day case and short stay surgery</td>
<td>81 trolleys</td>
</tr>
<tr>
<td>Site</td>
<td>Ward</td>
<td>Specialty</td>
<td>Beds</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------</td>
<td>-----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Theatres</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ward 305</td>
<td>General surgery/vascular surgery</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Ward 306</td>
<td>Cardiac surgery</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Ward 409</td>
<td>Neurosurgery</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Ward 410</td>
<td>Trauma</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Ward 412</td>
<td>Trauma</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Ward 620</td>
<td>Surgical assessment unit</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Ward 624</td>
<td>Urology/ENT/MaxFax/plastics</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td></td>
<td></td>
<td><strong>252</strong></td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>Ward 14</td>
<td>Elective urology/general surgery and urology daycase/treatment centre</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Ward 15</td>
<td>Elective orthopaedics</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td></td>
<td></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provides two nationally commissioned transplant programmes:
- Heart / lung
- Liver

Birmingham Heartlands Hospital hosts the regional thoracic surgery service and is home to the vascular hybrid operating theatre.

(Source: Acute Provider Information Request – Context acute tabs)

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust had 46,812 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 14,392 (30.7%), 23,026 (49.2%) were day case, and the remaining 9,394 (20.1%) were elective.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust had 59,370 surgical admissions from April 2017 to March 2018. Emergency admissions accounted for 19,116 (32.2%), 33,370 (56.2%) were day case, and the remaining 6,884 (11.6%) were elective.

(Source: Hospital Episode Statistics)

A range of surgical specialties provide surgical services at Heartlands hospital, including, general surgery, ENT, vascular, urology, trauma and orthopaedics and ophthalmology.
We carried out an inspection from 17 October 2018 to 19 October 2018. Our inspection was unannounced. Prior to the inspection we reviewed information we had about the service and information from stakeholders.

The surgical inspection team consisted of an inspector, an assistant inspector, two specialist advisors and a pharmacy advisor. We visited all the surgical wards, the day surgery unit, operating theatres and recovery areas.

During the inspection visit the inspection team:
- Spoke with 15 patients who were users of the service
- Spoke with the managers or the nurse in charge for each of the wards and clinical areas
- Spoke with 49 members of staff including senior managers, doctors, nurses, health care assistants, advanced clinical practitioners, administrative staff, housekeeping staff, housekeeping assistants and allied health professionals
- Reviewed parts of 13 patient care records relating to assessments, care plans, medicines administration and observation charts

Following the inspection, we reviewed additional performance data and other information provided by the trust.
**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to all staff. Overall completion rates for nursing staff were above the trust target of 90% and all modules were above 80%. Overall completion rates by medical staff were below the target at 82% although completion of most modules was above 75%.

**Mandatory training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Birmingham Heartlands Hospital**

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>298</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>298</td>
</tr>
<tr>
<td>Medicines management</td>
<td>296</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>288</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>277</td>
</tr>
<tr>
<td>Waste management</td>
<td>273</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>271</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>264</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>260</td>
</tr>
<tr>
<td>Fire safety</td>
<td>258</td>
</tr>
<tr>
<td>Information governance</td>
<td>247</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>243</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall training compliance rate of 91.3% for qualified nursing staff. The trust’s 90% completion target was met for seven of the 12 mandatory training modules for which qualified nursing staff were eligible. The resuscitation - clinical module had the lowest completion rate, at 81.8%.
A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in surgery at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major incident awareness</td>
<td></td>
<td>247</td>
<td>248</td>
<td>99.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate induction</td>
<td></td>
<td>237</td>
<td>248</td>
<td>95.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td></td>
<td>237</td>
<td>248</td>
<td>95.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td></td>
<td>223</td>
<td>245</td>
<td>91.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td></td>
<td>221</td>
<td>249</td>
<td>88.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td></td>
<td>204</td>
<td>248</td>
<td>82.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td></td>
<td>201</td>
<td>248</td>
<td>81.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td></td>
<td>190</td>
<td>247</td>
<td>76.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td></td>
<td>178</td>
<td>248</td>
<td>71.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td></td>
<td>175</td>
<td>248</td>
<td>70.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td></td>
<td>170</td>
<td>246</td>
<td>69.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Waste management</td>
<td></td>
<td>159</td>
<td>248</td>
<td>64.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall training compliance rate of 82.2% for medical staff. The trust’s 90% completion target was met for four of the 12 mandatory training modules for which medical staff were eligible.

The trust used a combination of on line training and face to face training to provide staff with mandatory training. Staff completion of mandatory training was recorded on an electronic system and managers were able to monitor their staff attendance as they could see the training records online. One ward manager told us they shared some administrative support with two other wards and that member of staff highlighted when staff required training updates. One ward manager said that resuscitation training was outstanding for some staff as there had been no dates available, however, they were now booked in for the training.

Nursing staff we spoke with said they were reminded when their training was due and said that the training was easy to access.

Ward managers were aware of the mandatory training completion levels for their ward and most told us they achieved the trust target of 90%. Compliance was slightly lower on ward 8 where the permanent ward manager was absent, however the ward manager covering the ward in the interim, told us they were focusing on recovering the position and it was a work in progress. They said that at the time of the inspection the ward was at 85% compliance.

Completion of mandatory training by medical staff was below the trust target however, senior leaders told us, completion of mandatory training was discussed at appraisal.

**Safeguarding**

*Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had a good knowledge of their responsibilities to report*
safeguarding concerns and make referrals. They were supported by the trust safeguarding team to do this.

The trust had policies for safeguarding adults and children and these were available to staff on the trust intranet. Staff were supported by the trust’s safeguarding team, who provided advice and support to staff. A flow chart, detailing action staff should take and the referral process, was provided by the trust safeguarding team. A ward manager told us they worked closely with the safeguarding team in making referrals and ensuring vulnerable patients were safe. Most wards had a safeguarding champion or link nurse, who were a local source of advice for staff. They attended additional updates from the trust’s safeguarding team.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

**Birmingham Heartlands Hospital**

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>297</td>
</tr>
<tr>
<td>Safeguarding Level 2 Children and Adults/ DoLs and mental capacity</td>
<td>295</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall safeguarding training compliance rate of 99.3% for qualified nursing staff. The trust’s 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible. There were only two members of staff who did not complete each of the safeguarding training modules.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in surgery at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>233</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>212</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall safeguarding training compliance rate of 89.9% for medical staff. The trust’s 90% completion target was met for one of the two safeguarding training modules for which medical staff were eligible.
Trust training included PREVENT awareness. PREVENT is one of the arms of the government’s anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation.

Awareness of female genital mutilation (FGM) was included in safeguarding training and staff had knowledge of the issue. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

Staff we spoke with said they had completed safeguarding training updates and this included PREVENT and FGM awareness. They told us they were confident to raise and report any safeguarding concerns. Most staff gave us examples of concerns they had raised and the action taken as a result. For example, a member of staff told us of an occasion when there were issues with family relationships and accusations of financial abuse of the patient. Staff took the appropriate steps to involve the safeguarding team, to ensure the patient’s wishes were identified and they were protected.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Audits were completed to ensure staff adhered to national guidance.

From October 2017 to September 2018 the trust reported 13 toxin positive Clostridium difficile (C. difficile) infections and five gene positive infections in surgery at Heartlands hospital. There were no Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia’s reported in the same period.

Screening of patients pre-operatively for carriage of MRSA has been a Department of Health recommendation since 2007 and trusts have policies to identify their approach to screening patients. Staff screened patients for carriage of MRSA prior to, or on, admission to surgery. Patients records contained pre-printed labels that staff completed to show that patients had been screened.

The trust monitored staff compliance with procedures which were recognised as having a high impact on the prevention of infection in hospital patients. These were procedures that should be followed when inserting and caring for peripheral and central venous cannulas and urinary catheters. Data collected by the trust and reported monthly, indicated there was 100% compliance with the procedures in September 2018.

The hospitals in the former Heart of England NHS trust which included Solihull hospital, submitted data for the national surgical site infection (SSI) audits for 2016/2017 for repair of fractured neck of femur and data showed the percentage of patients developing an infection was in line with other trusts. They did not submit data for the SSI surveillance programme for hip or knee prosthesis. However, they sent us a copy of work they had been undertaking to investigate and improve surgical site infections in orthopaedic surgery. The trust also had an extended scope practitioner referral pathway for prosthetic joint infection. In addition, the colorectal surgical speciality completed a local surgical site infection audit. The results of this are reported under patient outcomes in this evidence appendix.

Hand gel was readily available at the end of all beds and handwashing facilities were available in all clinical areas. During the inspection, we observed good compliance with hand hygiene procedures and the trust’s ‘bare below the elbows’ policy. Patients told us staff always used the hand sanitiser before providing care. One patient told us they had a drain removed and they observed the member of staff wash their hands and put on gloves before removing the drain. However, a patient told us they observed a nurse with a heavy cold sneezing into their hands whilst administering medicines and they did not wash their hands.
We observed staff in the operating theatres undertaking hand washing using the appropriate technique. Data provided by the trust indicated 100% compliance in monthly hand hygiene audits for most surgical wards and operating theatres, in the months when audits were undertaken, from April 2018 to September 2018. However, compliance was lower on ward 5 and ward 9 at approximately 90% in the same period.

Personal protective clothing and equipment (PPE) were available within clinical areas and we observed staff using them when providing care. Staff in the operating theatres wore the correct attire with hats covering their hair, appropriate theatre footwear and face masks. Staff followed the surgical hand asepsis technique and donned gowns and gloves using the sterile technique as per National Institute for Health and Care Excellence (NICE) CG74 guidance.

The clinical environment appeared visibly clean during the inspection and patients we spoke with told us the housekeeping assistants cleaned all areas thoroughly and regularly. We spoke with a housekeeping assistant and they were clear about the correct practices and procedures for routine cleaning and for cleaning when a patient had an infection. They told us they could contact the infection prevention and control team if they had any concerns or queries. Curtains used to surround each bed space were disposable and those we checked that were labelled, had been replaced within the previous six months. However, not all curtains were labelled with the date they had been replaced, which meant it was not possible to ensure they were replaced on a routine basis.

Waste was appropriately segregated and sharps were disposed of in the correct receptacles that were labelled with the location and date they were put into service.

**Environment and equipment**

The service had suitable premises and equipment and mostly looked after them well. **However, we identified some concerns in relation to the environment in the operating theatres.** The airflow exchange in parts of the operating theatres did not meet with Department of Health guidance. In addition, we found the contents of emergency trolleys used in the operating theatres were not always checked daily, which had the potential to impact on the safety of care.

Wards and departments had secure entry systems to enable staff to monitor people entering and leaving the wards. Visitors gained access by ringing a bell by the entrance to the ward. The wards were arranged in six bedded bays with a small number of single rooms. Piped oxygen and suction equipment was available at each bed space, as well as call bells for patients and for emergency use. There were sufficient toilet and bathroom facilities which were designated as single sex in line with Department of Health guidance and adapted for the safety of patients with a disability.

At the time of the inspection, several surgical wards were temporarily re-located to allow for essential fire safety work to be completed. Staff had taken steps to ensure storage areas were used appropriately and equipment was stored safely in the new areas in the interim. There was limited storage areas available for the storage of large items such as hoists and on ward 8 for example, a hoist, stand aid, and bed were stood near the entrance to the ward on the day we inspected. Although they were not causing an obstruction to those entering and leaving the ward, it meant that it caused issues when the hostess trolley was brought out to serve lunches.

The trust had arrangements for the maintenance of medical devices in accordance with the Medicines and Healthcare products Regulatory Agency (MHRA) Managing Medical Devices (April 2015), and other national guidance. Equipment we checked in the wards and operating theatres showed evidence of electrical safety checks and required maintenance. Medical gases were stored appropriately and secured using bespoke wall holders. Sterile supplies and consumables we checked were within their use by date.
There was sufficient equipment such as vital signs observation equipment, commodes and moving and handling equipment, on surgical wards to meet patient’s needs. Staff told us they had a mix of older manually operated hospital beds and newer electric profiling beds. This, sometimes created challenges for staff in ensuring profiling beds were available for patients with mobility issues and those who required assistance with positioning post-operatively. Alternating pressure mattresses and pressure relieving cushions, used for patients at risk of developing pressure ulcers, were supplied through a contract with an external manufacturer. Staff told us they were supplied in a timely manner and we saw there were arrangements in place for the receipt of new mattresses and return of used mattresses when patients no longer required them.

Bariatric surgery was undertaken at the hospital and staff had access to the required equipment to accommodate patient’s needs and maintain their safety.

A contract was in place with an external supplier for the sterilisation of theatre instruments and trays. These were mostly processed in a timely manner. However, theatre staff (band six) were responsible for checking and arranging the repair or replacement of instruments as required. Although this did not create safety issues, alternative arrangements would enable theatre staff time to be used more effectively, particularly in view of the volume of staff vacancies in the department.

Resuscitation equipment was stored in resuscitation trolleys in each clinical area. The trolleys did not have tamper proof drawers; however, all equipment was stored in plastic wrapped packs which were sealed and it would be evident if the packs were opened. Staff recorded daily checks of the resuscitation trolleys on the wards and in theatres and recovery.

Operating theatres had trolleys prepared with equipment required in emergency situations such as adult and paediatric emergency trolleys, awake intubation box and difficult airway trolleys. These should be checked daily to ensure the contents are correct. We found inconsistencies in the completion of the checklist, indicating that the contents were not always checked daily. For example, there were gaps on the week of the inspection for 15 October, 16 October and 17 October 2018. A member of staff told a member of our inspection team that the checklists had been recently introduced. However, checking of this type of equipment daily is essential to ensure all the equipment required is immediately available in an emergency situation.

In recovery we saw some equipment checks were not completed in line with the requirements stated on the checklist. For example, the blood gas analyser had not been checked for three consecutive days in October, and a vapour free machine was checked monthly when it should have been checked weekly.

**Assessing and responding to patient risk**

Staff completed and updated most risk assessments for each patient. They kept clear records and asked for support when necessary. However, processes to ensure the safety of patients undergoing surgery were not always followed in theatres. In particular, we found variable compliance with the surgical safety checklist and premature completion of instrument checklists. The consistent use of these checklists is key to eliminating surgical errors.

Patients admitted for elective (planned) surgery attended for a pre-operative assessment and staff assessed their individual risk in line with guidance on pre-operative assessment from the modernisation agency. A standard proforma was used by staff, to ensure a consistent approach was taken. The service used the American Society of Anaesthetists (ASA) classification system to grade a patient’s level of risk and plan the patients care accordingly. We found evidence of this in patients’ care records.
Medical and nursing staff completed risk assessments when patients were admitted for surgery. Nursing staff used standardised tools to assess patient's risk of developing pressure ulcers, falls, nutritional risk and risks associated with moving and handling. These risks were reviewed regularly. Where patients were identified as being at risk, plans to reduce the risks were in place. For example, when patients were at risk of developing a pressure ulcer, pressure relieving equipment was used and the patient was assisted to change their position on a regular basis. Nursing staff used a care bundle to record re-positioning and other interventions to prevent pressure ulcers developing. We reviewed a sample of these and found they were completed to demonstrate patients were being checked and assisted to move their position regularly.

NICE guidance (NG89) published in March 2018 states that all surgical and trauma patients should be assessed to identify the risk of VTE (venous thrombo-embolism or blood clots) as soon as possible after admission to hospital or by the time of the first consultant review and that reassessments for VTE should be at the point of consultant review or if their clinical condition changes. VTE risk assessments were completed electronically in conjunction with the electronic prescribing system.

Data provided by the trust as part of the ward quality indicators showed that compliance with VTE risk assessment met or exceeded the trust target of 95% consistently from September 2017 to August 2018 onwards. The remaining surgical wards achieved a compliance of at least 90% consistently in the same period, except for one month on ward 9 where the compliance was 84% in May 2018.

Nursing staff completed a pre-operative checklist to ensure the required safety checks were made prior to the patient’s transfer to theatre. We observed the pre-operative checks being completed in the day surgery unit by the nurse and the checklist was completed in full. When the patient was transferred into the anaesthetic room, a theatre practitioner re-checked the patient’s identity band against the collection slip.

We observed the initial briefing prior to the start of two theatre lists. On both occasions there was a full discussion of each patient on the list and the briefing was interactive with all members being given the opportunity to raise any issues. However, on one occasion the operating list was changed at the brief and an additional patient was added and the order changed. This was handwritten on the list. Best practice standards published by the Association for Perioperative Practice (AfPP 2016) recommend that changes should not be made on the day of surgery and if changed the list should be re-printed.

To reduce and potentially eliminate errors occurring in the operating theatre, the trust used the World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. However, when we observed the use of the checklist in the operating theatres during the inspection, we found variable adherence to the principles and practices. We observed “Sign in” for two patients in the ENT theatres which was not verbalised, although the preoperative checks in the anaesthetic room covered the checks. On one occasion the sign in could not be completed on the electronic tablet due to IT issues. During “Time out” a doctor was undertaking hand asepsis was talking to another member of staff in the scrub area during time out. All elements of the section were verbalised by the circulating practitioner and the remainder of the team were focused on it. In theatre 4 we observed the sign out was completed at the surgeon’s request whilst the skin was being closed. All members of the team were present but it was done prematurely. However, we observed other instances when compliance with the WHO checklist was good.

We also observed two occasions when the instrument tray checklist was completed pre-operatively and the post-operative checklist was ticked and/or signed prior to the end of the procedure.

We observed an emergency urology procedure. We found open systems were in use with no clear labelling on the gallipot or syringe in the sterile field. Two different methods of securing red tags
were observed during the inspection. On this occasion the red tag was secured on the handle of the Instrument basket. A member of staff described two different methods of securing the red tag. A previous incident had occurred regarding red tags and a standardised approach should be adopted. The post-op instrument check on the ureteroscope (long R Wolf 5 degree) was completed mid-case rather than at the end of the case.

The trust told us compliance with the WHO checklist was audited by three different approaches. Firstly, checklist compliance was audited for every checklist in the trust to ensure that the checklist has been adequately completed and these figures are reported monthly to the trust's clinical quality monitoring group. Secondly, compliance in terms of comparison between number of operations performed and number of checklists completed was monitored quarterly. These two steps ensured the checklist was completed for every operation. Lastly, they said an observational audit was undertaken six monthly to provide a qualitative aspect to auditing WHO compliance; this involved staff directly observing the completion of the WHO checklist in theatres. Staff we spoke with were not aware of any regular observational audits of the WHO checklist. Given the never events at some of the other trust sites over the previous 18 months, it was of concern that there had not been a previous focus on compliance with the checklist on a more regular basis.

Ward staff used the modified early warning score (MEWS) when they completed vital signs observations to identify deteriorating patients. This is in line with national guidance. The MEWS documentation included clear directions for staff on the action they should take if the MEWS score increased, indicating the patient's condition was deteriorating. We checked the observation charts for six patients and found the MEWS score was recorded with every set of observations. In instances when the score had increased, staff had taken action to alert the doctors or critical care outreach team to the issue. Notes written by medical staff and the critical care outreach team, indicated the patient was reviewed in a timely manner following escalation.

Nursing staff we spoke with were aware of the MEWS escalation process and said they received a prompt response when they contacted the medical staff or critical care outreach team.

Data collected by the Matrons as part of the ward quality indicators from September 2017 to August 2018, showed 100% escalation of MEWS in most cases and review of patients in response.

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. The trust had a sepsis protocol and used the national ‘Sepsis 6’ pathway to identify and treat sepsis. Managers told us sepsis training was included in the training provided on MEWS. Data provided by the trust (DR191) showed sepsis training was provided as part of the new staff induction training in 2017 and 2018, and 26 staff from the surgical wards had attended the training.

Staff we spoke with were aware of the importance of identifying possible sepsis and providing interventions in a timely manner. We noted that the vital signs observation charts prompted staff to consider the possibility of sepsis when the MEWS score increased. We noted that charts had been completed to document interventions in relation to sepsis.

The senior management team for surgery told us they were in the process of developing Local Safety Standards for Invasive Procedures (LocSSIPs) in line with national guidance. The minutes of some of the specialty governance meetings showed they were being developed and discussed and the trust provided us with a copy of some of the LocSSIPs following the inspection. However, staff in theatres were unaware of the initiative and of the progress being made.

**Nurse staffing**

The service had enough nursing and theatre staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, vacancies on some wards resulted in sub-optimal staffing levels and the requirement to use temporary staffing.
The trust used the national safer nursing care tool to review and set their nurse staffing levels. Staff told us the tool was used annually and when there was a change in the ward which might influence staffing requirements. However, there were high levels of registered nurse vacancies on some wards which impacted on staffing levels. Ward managers told us there were ongoing recruitment initiatives including monthly recruitment events and ongoing bespoke advertisements and matrons confirmed this. They told us that in the longer term they were developing the role of the assistant practitioners and exploring rotational posts. In the shorter term, some wards booked specific agency nurses for a block of shifts to improve continuity of care and ensure staff were conversant with trust policies and procedures. Nurse staffing was identified as a risk on the divisional risk register.

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in surgery.

The overall fill rate for qualified nursing staff dropped from 87.5% in March 2018 to 85.6% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>1,199.7</td>
<td>1,268.6</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>291.9</td>
<td>398.5</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>163.3</td>
<td>203.9</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>79.5</td>
<td>111.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 15.5% for nursing staff in surgery. This was higher than the trust target of 5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors vacancy rates for trends and spikes and benchmarks the activity.

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 8.7% for qualified nursing staff in surgery. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 2.8%
- Birmingham Heartlands Hospital: 20.4%
• Good Hope Hospital: 12.9%
• Solihull Hospital: 14.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From April 2017 to March 2018, the trust reported a sickness rate of 5.0% for qualified nursing staff in surgery. This is above the trust targets of 3.6% for Queen Elizabeth Hospital, and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

• Queen Elizabeth Hospital: 5.7%
• Birmingham Heartlands Hospital: 3.6%
• Good Hope Hospital: 5.0%
• Solihull Hospital: 4.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Birmingham Heartlands, Good Hope and Solihull Hospitals
From April 2017 to March 2018 the trust reported that for qualified and unqualified nursing staff 4.7% of actual hours were filled by agency staff and 15.9% by bank staff across Birmingham Heartlands, Good Hope and Solihull hospitals. The number of unfilled hours, a breakdown by site and staffing type was not provided.

(Source: Nursing bank agency - HGS PIR Return)

At the time of the inspection ward managers reported the highest levels of registered nurse vacancies on ward 4 with 17 WTE vacancies and ward 8 with 14 WTE vacancies. In addition, ward 11 had eight registered nurse vacancies and three nurses on maternity leave.

Ward 4 cared for mainly thoracic and vascular surgical patients and incorporated six high dependency beds. We were told a review of the acuity of patients on the ward was being undertaken to assess the required staffing levels, as changes in the patient pathways was impacting on the dependency of patients on the ward. It was recognised there was increased use of laparoscopic (keyhole) surgery and the length of stay of patients was decreasing. The ward manager said they felt the staffing levels were safe and if the acuity of patients increased they could ask for additional staff, or patients could be diverted to the high dependency beds on the intensive care unit.

Ward 8 and ward 9 were trauma and orthopaedic wards. The ward manager from ward 8 was also covering ward 9 due to the absence of the permanent ward manager. For a period from August 2018, ward 9 had been relocated to ward 17 in order to enable essential safety work to be completed in the hospital and due to the size of the ward, the bed numbers were reduced. As a result, three registered nurses from ward 9 had been temporarily moved to ward 8 and this, along with the block booking of three agency nurses, had mitigated the impact of the vacancy levels at the time of the inspection.

Ward 11 contained a surgical assessment unit and general surgery inpatient beds. Staff on the ward felt the needs of the high volume of patients going through the assessment unit was not adequately reflected in the assessments of staffing requirements. They told us there was also a
high turnover of staff and these factors impacted on staff morale. Staff said they were frequently one member of staff short on shifts and this impacted on the timeliness of care and discharges. Staff also told us that most agency nurses were unable to administer medicines using the electronic medicines system, administer intravenous drugs, or insert peripheral cannulas. This reduced the effectiveness of the agency staff in comparison to permanent staff.

A matron was allocated daily to oversee staffing for the division and they assessed the acuity of patients, moving staff where necessary to ensure patient safety. Staff told us they felt the decision making was fair and all areas were dealt with equitably. However, a member of staff on ward 11 told us they rarely saw a matron or senior managers on the ward and they did not think there was a full understanding of the issues on the ward in relation to the volume of patients.

Two band seven staff managed theatres on a daily basis. Theatres were staffed in line with the recommendations of the Association for Peri-operative Practice (AfPP). However, they were heavily reliant on bank and agency staff. Staff told us that current rota gaps were on average 14 shifts per day, or 70 per week. On one inspection day, there were 11 qualified bank or agency staff members present. Despite the amount of temporary one of the band sevens told us that the skill mix was reviewed daily ensure patient safety and due to knowledgeable staff and long-term agency staff they felt the department was safe. Theatre staff were speciality specific and there was no formal rotation. However, staff moved to another speciality on a day by day basis due to skill mix gaps and in case of need. There was a set night team. Night staff rotated on to days for two shifts every three months to ensure their skills and competencies were maintained. However, they were not supernumerary and there was no log to evidence learning.

Agency staff were orientated to the ward on their first shift and the nurse in charge went through policies and procedures with them. Staff told us they received a comprehensive handover at the start of each shift and we saw a printed handover sheet which contained key information about each patient and their specific care needs.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm. However, we identified concerns in relation to out of hours provision, the volume of general surgical emergency patients and the high use of temporary staff. This impacted on the timeliness of care and the pressures on medical staff out of hours.

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in surgery.

The overall fill rate for medical staff dropped from 94.9% in March 2018 to 90.9% in June 2018. Solihull Hospital has a particularly low rate, with only one member of staff in post out of a planned five in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>Actual staff – WTE in month</th>
<th>Planned staff – WTE</th>
<th>Fill Rate</th>
<th>Actual staff – WTE in month</th>
<th>Planned staff – WTE</th>
<th>Fill Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>586.6</td>
<td>556.3</td>
<td>105.5%</td>
<td>774.6</td>
<td>805.2</td>
<td>96.2%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital, Good Hope, and Solihull hospitals</td>
<td>357.9</td>
<td>439.0</td>
<td>81.3%</td>
<td>357.0</td>
<td>421.5</td>
<td>84.6%</td>
</tr>
</tbody>
</table>
Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 11.3% for medical staff in surgery. This was higher than the trust target of 10% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors vacancy rates for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 3.6% - this indicates staffing being over planned levels.
- Birmingham Heartlands Hospital: 23.8%
- Good Hope Hospital: 7.2% - this indicates staffing being over planned levels.
- Solihull Hospital: 50.0%

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 7.0% for medical staff in surgery. This is below the trust target of 8.5% for Birmingham Heartlands Hospital and Good Hope Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 4.6%
- Birmingham Heartlands Hospital: 9.5%
- Good Hope Hospital: 15.5%

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 1.1% for medical staff in surgery. This is below the trust targets of 3.6% for Queen Elizabeth Hospital, and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and their community locations.

A breakdown by site is below:

- Queen Elizabeth Hospital: 1.0%
- Birmingham Heartlands Hospital: 1.4%
- Good Hope Hospital: 0.6%
- Solihull Hospital: 9.1%

The rate for Solihull is above the target of 4.0% for this site, but relates to a small number of staff.
Locum and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From April 2017 to March 2018 the trust reported that 10,444 shifts were filled by agency medical staff, 8,034 by locum medical staff and that 1,292 were left unfilled.

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>4,831</td>
<td>1,736</td>
<td>747</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>3,948</td>
<td>2,969</td>
<td>386</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>936</td>
<td>2,425</td>
<td>105</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>729</td>
<td>904</td>
<td>54</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In May 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Staffing skill mix for the whole time equivalent staff working at University Hospitals Birmingham NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>53%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>10%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Surgical consultants in each specialty were present on the site daily and provided on call cover out of hours. Most surgical consultants cared for patients on other trust sites, in addition to Heartlands hospital. A consultant raised a concern about the on call rota, due to the volume of emergency general surgical patients, which totalled between 40 and 60 patients in 24 hours and the seniority and expertise of some of the junior doctors. As a result, the consultant on call was regularly up for most of the night and then had a full schedule the following day.
All patients were seen by medical staff on a daily basis. In some specialties, consultants carried out ward rounds daily whilst for others, the consultant completed a ward round twice a week and a registrar completed the ward rounds on other days. There was a consultant presence on site at weekends.

Teams of specialty and junior doctors were available to support each specialty. Historically, there were gaps in the junior doctor rotas due to insufficient numbers of junior doctors. However, at the time of the inspection, we were told that all the first and second year foundation doctors and core trainee posts were filled. There were some gaps at specialty level, although they were filled with locum doctors.

The surgical division had explored options to supplement the numbers of junior doctors. This included recruiting to non-training junior doctor roles, including recruiting international training fellows. In addition, they were developing advanced care practitioner roles in most specialties. Advanced care practitioners (ACPs) are staff who have completed formal training to enable them to undertake most elements of the junior doctor role. An ACP said the intention was to provide continuity of care, however they found themselves working on different sites on a day to day basis. The senior management team told us they had identified initial challenges in the utilisation of advanced care practitioners and were currently re-designing the service with the involvement of one of the first ACPs to be appointed. They recognised that initially, they were used to bridge the gaps in staffing and this was not ideal.

Following a General Medical Council survey, the management team said they had been rigorous in addressing the induction process for junior doctors. An international doctor told us they had been allocated shadow shifts for the first month and they had a mentor. They felt well supported.

Records

**Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

Information needed to deliver safe care and treatment was available to staff in a timely way. Records of the current hospital admission were stored in locked trolleys, with keypad access, in each ward area and patients’ past medical records were stored separately in locked cupboards. Records of nursing assessments and daily nursing care were stored separately in folders by each patient’s bed. Therapies and other staff documented daily care in the medical records. This meant staff were able to access the information they required to provide safe care and treatment.

We reviewed 13 patient records. Entries were legible, dated, timed, signed and the designation of the person making the record was recorded in line with required practice. Records of the pre-
operative assessment and initial admission assessment were completed consistently using a pre-printed proforma to ensure all the required information was obtained. Staff completed a surgical inpatient pathway or day case surgery pathway to record the information throughout the patient journey. Theatre, anaesthetic and recovery notes were completed and the patient record contained, theatre tray identification labels and implant/prosthesis labels. Nurses completed a pre-operative checklist to show the necessary checks were completed and documentation completed, prior to the patient’s transfer to theatre. Nursing assessments and care plans were completed and we saw that when patients had additional needs some of these were identified and care plans put into place. For example, urinary catheter management plans were in place. However, when people were living with dementia we did not see care plans that identified their particular needs.

Observation charts were completed accurately and consistently and care bundles were used to record interventions to reduce risks of patients developing pressure ulcers. This showed patients were being monitored and reviewed regularly.

On discharge from hospital, a summary of the admission and treatment provided was sent to the patient’s GP. The trust used an electronic system to produce the discharge summary and the order for medicines for the patient to take home. A copy of the discharge summary was sent electronically to the patient’s GP and the patient was given a copy to take home. Staff told us discharge summaries were produced before the patient left hospital.

Medicines

Medicines were not always managed safely. We observed two occasions on a ward when a medicines trolley was unlocked and unattended. Storage areas were congested and we saw there were occasions when a medicine was missed due to staff being unable to locate it, or there were delays in obtaining a medicine from pharmacy. The temperature of refrigerators used for medicines storage on the wards were not monitored consistently and when they were above recommended limits, action was not always taken to report this to pharmacy.

Medicines were mostly stored safely in locked cupboards and refrigerators behind locked doors, or in restricted areas which were only accessible to authorised staff. However, we observed two occasions when a trolley containing medicines was left unlocked and accessible to others. On one occasion when a nurse was administering medicines from a medicines trolley, they left the trolley unlocked and unattended whilst they were administering another person’s medicines behind closed curtains. Staff in the wards and the operating theatres completed regular checks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), and recorded their use in line with requirements. We carried out random checks of a sample of controlled drugs and the numbers correlated with the controlled drugs register. However, we found some medicines trolleys and cupboards were very congested and untidy. In addition, some intravenous fluid storage areas were untidy and fluids containing potassium were not segregated appropriately.

Checks of the temperatures of the rooms used to store medicines were introduced the week prior to the inspection and had been checked daily in most cases. however, staff were not always clear about the recommended temperature limits and the action to be taken when the temperature exceeded the recommended limits. For example, room temperatures of above 25°C, were recorded in the medicines storage room on ward 8 since the introduction of the recording and the thermometer had simply been reset, instead of escalating to estates and pharmacy except on one occasion on 15 October. Refrigerator temperatures with maximum/ minimum readings were recorded; however, most staff we spoke with, did not know how to reset these and when readings were above recommended limits, no action was taken.
Medicines for use on the wards were prescribed and administered electronically. Nursing staff used the system to view the medicines which were due, and to record when they had given the medicine. Allergies and venous thrombo-embolism (VTE) assessments were also recorded on the system. We observed staff administering medicines and found they completed the necessary checks prior to administering each person’s medicines. Patients told us staff always checked their name and date of birth and/or their identity band prior to administering their medicines.

However, we found there were some delays in obtaining medicines for patients at times. For example, a member of staff had recorded that a patient’s medicines were ordered from pharmacy in the morning and didn’t arrive until 7pm. This included a medicine for Parkinson’s disease; which should be given at set time intervals to ensure it remains effective. A patient also complained to us that there was an initial 20 hour delay in the administration of their anti-inflammatory medicine when they were transferred from another hospital. When we checked their medicine prescription with the ward sister, they identified that the delay was much shorter and may have occurred due to their transfer. We also saw a record of a delay in the administration of antibiotics due to delays in obtaining them from pharmacy. A member of staff told us they often went down to pharmacy to collect antibiotics if they needed them urgently. We spoke with a pharmacy technician who told us the trust had introduced a process to prioritise the provision of antibiotics within one hour of booking. However, due to the volume of orders, there were sometimes extended waits.

We also identified an issue with antibiotic stewardship. When antibiotics are prescribed, a review date should be recorded, to ensure antibiotics are not continued for any longer than is necessary. This was not in place and we were told the electronic prescribing and administration system treated a review date as an automatic stop date, therefore medical staff were reluctant to use it in case the antibiotics needed to be continued.

Incidents

Staff recognised incidents and reported them appropriately. Managers investigated incidents and action was taken to prevent recurrence. However, staff did not always receive feedback about incidents and lessons learned were not always effectively communicated to staff, particularly in relation to learning from incidents on other sites. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From August 2017 to July 2018, the trust reported four incidents classified as never events for surgery:

- Wrong site surgery in October 2017 at Queen Elizabeth Hospital
• Wrong site surgery in November 2017 at Queen Elizabeth Hospital
• Wrong site surgery in April 2018 at Queen Elizabeth Hospital
• Retained foreign object in April 2018 at Good Hope Hospital

(Source: Strategic Executive Information System (STEIS))

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust reported one incident classified as a never event for surgery. This related to wrong site surgery and occurred at Birmingham Heartlands Hospital in October 2017.

Theatre staff were aware of the never event in relation to a retained foreign object at the Good Hope hospital and said the root cause analysis was ongoing. However, they did not mention the wrong site surgery at the Heartlands hospital which was an incident related to the removal of a foreign object from an ear. Although we were told compliance with the WHO checklist had improved, we found variable adherence to the procedure in practice and this suggested that further learning could be achieved. There was little evidence that managers had undertaken observational audits to monitor compliance and determine whether further learning was required.

Breakdown of serious incidents reported to STEIS

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 33 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England occurring from August 2017 to July 2018.
The breakdown by type of incident reported were:

- Surgical/invasive procedure incident with 11 (33.3% of total incidents)
- Slips/trips/falls with six (18.2% of total incidents)
- Pressure ulcer with five (15.2% of total incidents)
- HCAI/Infection control incident with five (15.2% of total incidents)
- Diagnostic incident including delay with two (6.1% of total incidents)
- Medication incident with two (6.1% of total incidents)
- Sub-optimal care of the deteriorating patient with one (3.0% of total incidents)
- Treatment delay with one (3.0% of total incidents)

Site specific information can be found below:

- Queen Elizabeth Hospital (August 2017 to July 2018): 23 incidents
- Birmingham Heartlands Hospital (April to July 2018): seven incidents
- Good Hope Hospital (April to July 2018): two incidents
- Solihull Hospital (April to July 2018): one incident

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2017 to March 2018.

The breakdown by type of incident reported were:

- Pressure ulcer with eight (34.8% of total incidents)
- Slips/trips/falls with six (26.1% of total incidents)
- Surgical/invasive procedure incident with three (13.0% of total incidents)
- Sub-optimal care of the deteriorating patient with two (8.7% of total incidents)
- Diagnostic incident including delay with two (8.7% of total incidents)
- HCAI/infection control incident with two (8.7% of total incidents)

Site specific information can be found below:
- Birmingham Heartlands Hospital: 13 incidents
- Good Hope Hospital: eight incidents
- Solihull Hospital: two incidents

(Source: Strategic Executive Information System (STEIS))

The trust carried out a root cause analysis (RCA) in relation to serious incidents and identified preventative actions. Ward managers told us they were involved in completing the RCA for pressure ulcers and falls and identification of learning.

The trust used an electronic reporting system for recording incidents and accidents and action taken as a result. Ward staff told us there was an open culture in relation to incidents; they were encouraged to report incidents and they were all able to enter the details of incidents onto the electronic reporting system. Several staff gave us examples of incidents they had reported. However, they said they did not always receive feedback from the incidents they reported. For example, a staff nurse told us they had reported unsafe staffing levels and they were not updated as to whether any action had been taken. Some staff also told us they rarely received any feedback from incidents or lessons learned.

From November 2014, trusts were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person. Staff we spoke with were aware of the duty of candour legislation and the importance of being open and transparent with patients and families when mistakes were made. A ward manager gave us an example of a time when they had applied the duty of candour in relation to a patient who injured themselves from a fall. They told us about the initial conversation with the patient and their relatives, the investigation and the subsequent letter of apology with results of the investigation.

The trust reported that awareness of being open and the duty of candour requirements was provided to staff at a number of training sessions. They said compliance was reported to divisions and specialties to increase awareness of the duty or candour requirements. Information was also available online.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.
Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services as all incidents were reported under the core service ‘Other’.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported 50 new pressure ulcers, eight falls with harm and two new catheter urinary tract infections from August 2017 to August 2018 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Heart of England NHS Foundation Trust**

1. **Total Pressure ulcers (50)**

2. **Total Falls (8)**

3. **Total CUTIs (2)**

Please note that this includes data for April to June 2018 which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.

(Source: NHS Digital)

The trust informed us a root cause analysis (RCA) was completed in relation to falls with injury and for pressure ulcers occurring following admission to hospital. Staff confirmed this and said the divisional head nurse and falls coordinator was involved in falls RCAs. They said the outcome of the RCA was entered onto the electronic incident system, including an action plan and the governance department requested an update when the action was due to be completed.
The nursing risk assessment completed when patients were admitted to hospital included an assessment of patient’s risk of developing pressure ulcers and of falling. From this, the level of risk was identified and a care plan put into place. However, in the case of one person whose care we reviewed we found the patient was not identified as at risk of falls on admission although they were confused and disorientated. A care plan was not put into place until after the patient had fallen. Their care plan also stated they required bedrails and no bed rails were in place. The patient was placed on enhanced observations, although the frequency of checks on their safety was not identified. We spoke with the ward manager about this patient and they told us the patient was confused and there were risks to the use of bed rails. They said the patient was placed in a bay where patients were at risk of falls and staff monitored the bay more closely.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Audits were completed to make sure staff followed guidance.

We reviewed a small sample of trust policies and guidelines and found these referenced national, best practice, guidance relevant to the subject. Staff were able to access clinical guidelines from the National Institute of Health and Care Excellence (NICE) from the trust intranet. Other national and local guidance was displayed on noticeboards within the ward areas. For example, the limb ischaemia pathway and guidelines and standard operating procedures for referral to other specialties was displayed on one ward.

The trust reported that all new NICE guidelines were identified at the end of each month and were sent to clinical leads for each specialty for implementation.

Staff told us that all policies and procedures for surgery were being reviewed and where possible aligned with those at the Queen Elizabeth hospital, to achieve consistency across the trust, following the acquisition. For example, a consultant told us colorectal surgery practice in relation to the prescribing of oral antibiotics and bowel preparation were being harmonised with the Queen Elizabeth hospital. The senior management team told us specialties were taking steps towards integration and review of pathways and procedures formed part of this.

The trust provided evidence that they completed audits to compare the care and treatment provided in each of the surgical specialties and whether this complied with NICE guidance for the procedures or other published data. For example, trauma and orthopaedics compared their results for hip resurfacing against published data and monitored the national joint registry results. They found their results compared favourably to other published studies and the national joint registry. They also reviewed their adherence to NICE guidelines for displaced intracapsular neck of femur fractures. They found 92.5% of patients received the appropriate surgical procedure in relation to NICE guidance. Urology also looked at their use of botox in the treatment of overactive bladder in accordance with the updated 2013 NICE guideline (CG171).

There was a programme of audit for each surgical specialty and the trust provided us with a sample of the audits completed and learning gained from them. As most of the surgeons at Heartlands hospital, also worked at Solihull hospital and/or Good Hope hospital, the results were sometimes specific to one hospital, when surgery was focused on one of the sites, and in other cases amalgamated results from more than one site. However, it was apparent from the data provided that each specialty audited and assessed their practice on an ongoing basis. Examples of local audits included, an audit of day case ambulatory care in vascular surgery, which led to an
improvement in the quality of discharge letters following the audit and an audit of the ‘stop before you block’ initiative in regional anaesthesia.

Thoracic surgery had an enhanced recovery forum. A consultant told us they had held a brainstorming session and looked at the patient journey from pre-operative care to surgery and through to discharge and outpatient follow up from the patient’s perspective. As a result, a number of improvements had been made in the provision of information for patients, the introduction of advanced care practitioners and the provision of a clinic for patients who had been discharged, prior to their follow up appointment.

Each specialty had a forward plan for audits for 2018/19, which included local and national audits, including assessment of compliance with NICE guidelines and trust policy.

Surgical services used some care pathways to ensure a consistent approach to the care and treatment of patients undergoing specific procedures. In addition, there was a day surgery care pathway and an inpatient surgical care pathway for routine procedures.

Staff used recognised tools where possible in the assessment of patients. These included occupational therapists using the Manchester mobility score to measure patient improvement, and wound assessment proformas. Nurses used established risk scores to assess risk of falls, pressure ulcers and nutritional risk. Care pathways were in place for blood transfusion and urinary catheter management.

Safety guidelines produced by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) were laminated and attached to the side of anaesthetic machines in the operating theatres. There were also emergency guidelines published by the Difficult Airway Society laminated in theatres.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. Patients had access to specialist advice and nutritional support as required. However, patient feedback about the quality of the food and choice at mealtimes was variable and some patients told us this affected the amount they ate.

Staff measured each patient’s nutritional status on admission to hospital using a national screening tool and a nutritional care plan was put into place, based on the results of this. Patient records indicated patients were reviewed by a dietitian when they were at high risk of malnutrition. We saw the advice of the dietitian was followed in relation to the provision of nutritional supplements. We also saw a referral to a speech and language therapist when it was thought a person was having difficulties in swallowing. Staff recorded patient’s nutritional intake on food charts when they required assistance to eat, or they were at risk of losing weight. We found these were generally completed well. When it was advisable to ensure a patient was drinking adequate amounts, but it was not necessary to accurately measure their intake and output, hydration charts were used to monitor the amount they drank.

Protected mealtimes were in operation on all the surgical wards we visited and we saw this was mostly adhered to. Visitors were able to stay if their relative needed some assistance and encouragement to eat.

Ward housekeepers discussed food choices with patients approximately 30 minutes before the meal was served. However, the kitchens sent a fixed number of portions for each option on the menu and if more patients chose an option than the number supplied, they were asked to choose another option. Patients we spoke with gave us negative feedback on the quality of the meals and told us the ward ran out of certain choices and this affected the amount they ate.
In the patient led assessment of the ward environment audit (PLACE) Heartlands hospital scored better than the national average for ward food, however, their score showed a downward trend in 2017 and 2018.

Prior to surgery patients were kept ‘nil by mouth’ and fasted in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Patients who were admitted to hospital on the day of surgery and day surgery patients, were provided with clear instructions about the need to fast before their surgery and the time when they could have their last food and drink. When the order of the operating list was changed, the anaesthetist contacted the ward to let the staff know the patient could have additional drinks where applicable.

Patients on the morning list were generally instructed not to eat after 2.30am or 3am and were told they could have clear fluids until 6am, whereas patients having their operation in the afternoon were able to have a light early breakfast. Patients told us they had been given written and verbal information about fasting times.

**Pain relief**

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

Patients care records showed that staff monitored patient’s pain and asked them about pain with every set of vital sign observations. The patient’s pain score was included in the vital signs observation chart alongside the MEWS. A visual tool with a series of sad and happy faces was printed in every patient’s nursing assessment booklet to use when a patient was unable to verbalise the level of their pain.

We observed a display with pain management information for patients on the noticeboard on ward 10. Patients we spoke with told us staff had managed their pain very well. One patient told us they had a form of intravenous analgesia that they controlled themselves (PCA). They said staff had explained they could press the button to initiate the injection of the pain relieving medicine and the pump controlled how often it was given, to ensure they could not give themselves too much. They said staff had explained they could ask for extra pain relief if necessary and staff gave them a different pain relieving medicine. Another patient said, “Pain control is very good. Nurses check after they have given it to make sure it has been effective.”

**Patient outcomes**

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Performance in national outcome audits was variable, with good outcomes in the national vascular registry, national emergency laparotomy audit and the national bowel cancer audit for example, whilst performance in the national hip fracture database audit was below the national average.

**Relative risk of readmission**

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

**Birmingham Heartlands Hospital – elective admissions**

From May 2017 to April 2018, patients at Birmingham Heartlands Hospital had a higher than
expected risk of readmission for elective surgical admissions compared to the England average.

Patients in urology, ENT and ophthalmology had higher than expected risks of readmission for elective admissions.

**Elective Admissions – Birmingham Heartlands Hospital**

![Bar chart showing expected risk of readmission for elective admissions]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**Birmingham Heartlands Hospital - non-elective admissions**

From May 2017 to April 2018, patients at Birmingham Heartlands Hospital had a higher than expected risk of readmission for non-elective surgical admissions compared to the England average.

Patients in general surgery, trauma and orthopaedics and urology had higher than expected risks of readmission for non-elective admissions.

**Non-Elective Admissions – Birmingham Heartlands Hospital**

![Bar chart showing expected risk of readmission for non-elective admissions]

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.*

**National Hip Fracture Database**

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

**Birmingham Heartlands Hospital**

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 6.5%
which was within the expected range. The 2016 figure was 7.1%.

The proportion of patients having surgery on the day of or day after admission was 47.3%, which failed to meet the national standard of 85%. This was within the bottom 25% of trusts. The 2016 figure was 65.7%.

The perioperative medical assessment rate was 94.9%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 85.5%.

The proportion of patients not developing pressure ulcers was 91.9%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 82.8%.

The length of stay was 22.1 days, which falls within the middle 50% of trusts. The 2016 figure was 20.0 days.

(Source: National Hip Fracture Database 2017)

The trust provided us with evidence that performance in the National Hip Fracture Database was discussed at their clinical audit meetings, however, we did not receive an action plan to address the areas where performance was below the national average. Senior clinicians identified issues with the sufficiency of trauma theatre time in comparison with the volume of patients. In addition, data entry onto the database was identified as an issue. The senior leadership team told us of plans to re-align trauma and orthopaedic services to achieve separation of trauma and elective patients. In addition, two full time ortho-geriatricians were in post to enable all patients with a fractured hip to be seen within 24 hours. These patients were then transferred to the care of an ortho-geriatrician following surgery.

Data from the National Joint Registry indicated that Solihull performed well in relation to other hospitals in terms of the standardised revision rate for hip and knee replacements and the standardised mortality rate. They achieved a green rating for all these indicators in 2017.

Bowel Cancer Audit

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 Bowel Cancer Audit, 68.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2016 figure was 69.8%

The risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The 2016 figure was 2.3%.

The risk-adjusted 2-year post-operative mortality rate was 21.9% which was within the expected range. The 2016 figure was 21.1%.

The risk-adjusted 30-day unplanned readmission rate was 11.3% which was within the expected range. The 2016 figure was 11.0%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 44.4% which was within the expected range. The 2016 figure was 44.4%.
National Vascular Registry

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.7% for Abdominal Aortic Aneurysms. This was within the expected range. The 2016 figure was 0.8%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 12 days, which was better than the audit aspirational standard of 14 days. The 2016 figure was also 12 days.

The 30-day risk-adjusted mortality and stroke rate was 3.7%, which was within the expected range. The 2016 figure was 2.9%.

National Oesophago-Gastric Cancer National Audit

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 National Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.0%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation.

The 90-day post-operative mortality rate was 4.0%. This was within the expected range. The 2016 rate was 6.1%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.7%. This was similar to the national aggregate. The 2016 figure was 33.7%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

National Emergency Laparotomy Audit

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.
The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

**Birmingham Heartlands Hospital**

In the 2016 National Emergency Laparotomy Audit (NELA), the Birmingham Heartlands Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 263 cases.

The site achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 159 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 150 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 106 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 263 cases.

We also examined the most recent data from the NELA database and saw they had achieved above the national average of 80% of the proportion of high-risk cases with a consultant surgeon and anaesthetist present in theatre and achieved 100% of cases with a consultant surgeon in theatre.

**Patient Reported Outcome Measures**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 performance on groin hernias was about the same as the England average for both indicators.

For varicose veins, scores for the Aberdeen Varicose Vein Questionnaire showed a higher proportion of patients that felt they had improved than the England average. However, for the varicose veins EQ VAS the trust had a higher proportion of patients who reported that they felt worse than the England average.

The trust did not submit any data for hip or knee replacements.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 performance on groin hernias was similar to the England average for the EQ VAS indicator but better for the EQ-5D Index.

For varicose veins, performance was better than the England average for both the EQ VAS and EQ-5D Index. Performance was similar for the Aberdeen Varicose Vein Questionnaire.

For hip replacements, performance was worse than the England average for the EQ VAS and similar to the England averages for EQ-5D and Oxford Hip Score.

For knee replacements was about the same as the England average for all three indicators.

(Source: NHS Digital)

The performance in the PROMs for hip and knee replacements may have been affected by a low patient participation rate. A senior clinician explained that an external organisation was not employed by the trust to follow up patients and encourage participation to increase participation rates. Heartlands hospital and Good Hope hospital cared for elective and trauma patients on the same ward. This has been shown to affect infection rates and outcomes.

Surgical services participated in the national radical prostatectomy outcomes project. Median post-operative stay was three days for open surgery and was in line with national data for laparoscopic surgery.

An audit to look at patients not attending their appointments (DNA) at the hospital was completed in ophthalmology. This identified a range of reasons why patients did not attend their appointment. Most of the reasons were outside the control of the service, however, there was a discussion within the directorate of ways in which DNAs rates might be reduced.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance to provide support and monitor the effectiveness of the service.

However:

Staff in recovery had not completed advanced life support training and there wasn’t a supernumery anaesthetist, although anaesthetists were available in theatres.

**Appraisal rates**

From April 2017 to March 2018, 89.9% of staff within surgery at the trust received an appraisal. This is below the trust target for Queen Elizabeth Hospital of 90% but above the target for other
sites of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>367</td>
<td>378</td>
<td>97.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>451</td>
<td>481</td>
<td>93.8%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>66</td>
<td>73</td>
<td>90.4%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>37</td>
<td>41</td>
<td>90.2%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>945</td>
<td>1,052</td>
<td>89.8%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>389</td>
<td>454</td>
<td>85.7%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>10</td>
<td>12</td>
<td>83.3%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>295</td>
<td>358</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

**Birmingham Heartlands Hospital**

From April 2017 to March 2018, 84.7% of staff within surgery at Birmingham Heartlands Hospital received an appraisal compared to a target of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>113</td>
<td>114</td>
<td>99.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>77</td>
<td>85</td>
<td>90.6%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>35</td>
<td>39</td>
<td>89.7%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>30</td>
<td>34</td>
<td>88.2%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>210</td>
<td>244</td>
<td>86.1%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>170</td>
<td>209</td>
<td>81.3%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>155</td>
<td>208</td>
<td>74.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Ward managers on each ward and the theatre manager showed us evidence that their appraisal rates at the time of the inspection were over 90%. They all had a list of those staff whose appraisal was due that month, to ensure they were completed in a timely way. The exception to the high rates of appraisal was ward 8, where the percentage of staff that had received an annual appraisal was 75%. The ward manager had been absent for an extended period and the ward manager from another ward was managing two wards. They told us they were catching up and the percentage was steadily improving. All the staff we spoke with during the inspection told us they had received an appraisal within the last 12 months. They said they had the opportunity to discuss their performance and their training and development needs.

Each ward had a range of champions or link nurses who had undertaken additional training in their link role to enable them to provide advice to other staff on the ward. They also provided practice based training or updates where appropriate. We saw there were link nurses for diabetes, safeguarding, tissue viability, medical devices for example.
Nursing and therapies staff told us they had access to training and development and were encouraged to extend their skills. Several courses were available with the initial training completed online following by practical face to face study day.

We observed staff providing care to patients competently and confidently. Patients told us they felt staff had the skills to care for them and they had trust in them.

Most of the recovery staff had not undertaken advanced life support training and a supernumery anaesthetist was not available. This does not meet the Association for Peri-operative Practice (AfPP) guidelines. We spoke with the matron for theatres and they told us there were anaesthetists available in theatres, however, they were not supernumery.

We also spoke with an advanced care practitioner (ACP). They told us they had attended recognised training at the local university. They told us the support to trainee ACPs had improved. Initially they felt they were asked to undertake duties such as on call without the necessary training or knowledge of protocols. However, the issues had been recognised and the preparation for participating in the on-call rota had improved considerably and ACPs did not participate in the on-call rota until they were fully qualified.

Medical trainees were able to attend regular teaching and had an allocated supervisor. The division had previously identified some imbalance between the opportunities for teaching and development for the non-trainee junior doctors and had worked to overcome this.

**Multidisciplinary working**

**Multidisciplinary team working was effective. Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide coordinated care.** We observed therapies staff were based on some wards and staff communicated well with each other.

Teams worked well together to improve the effectiveness and timeliness of care through good communication. Relevant staff teams and services were involved in assessing, planning and delivering patient’s care and treatment and worked together to understand and meet the range and complexity of patient’s needs.

Nurses attended daily ward rounds with medical staff to ensure good communication and handover of changes to the plan for the patients.

On the orthopaedic wards, physiotherapists and occupational therapists were based on the wards and worked jointly together to provide therapy input for patients. They attended a weekly multidisciplinary meeting with the other professionals and attended a daily handover with the nurses.

We also spoke with one of the thoracic therapy team and they told us patients were referred to them as required. They said they worked well with the medical and nursing teams and although they didn’t attend ward rounds, they received a good level of information about the patients referred to them. They said they felt they were treated as equal members of the team and their views were listened to.

A ward housekeeper told us they felt part of the team and a patient we spoke with, commented, “The domestic staff are part of the team and are very responsive.”

Two ortho-geriatricians were available and saw patients with fractured hips on admission and patients were transferred to their care following surgery.

**Seven-day services**

The service was working towards seven-day services. Surgical consultants were available on site seven days a week and physiotherapy and occupational therapy operated a seven-
day service. Pre-assessment clinic and the day procedures unit were operational during defined hours.

Patients told us they saw a doctor every day, although this was not always a consultant. There was a consultant presence on site at the weekend and they were available on-call overnight.

The day surgery unit was open Monday to Saturday from 7.30am to 8pm. The day surgery theatre list commenced at 9am and finished at 6pm.

There was access to theatres 24 hours a day, seven days a week. Anaesthetists provided an on-call service out of hours. The critical care outreach team or hospital at night team were available 24 hours a day.

The main pharmacy departments were open from 9am to 5pm Monday to Friday, and 9am to 4pm Saturday, Sunday and Bank Holidays. An on-call service operated outside these hours.

Health promotion

The service provided a range of information leaflets for patients in a range of formats. These included locally produced leaflets and leaflets provided by national organisations and charities.

We observed some health promotion information, particularly in the surgical assessment unit waiting area. These included signs of blood clots, a patient’s guide to strokes and atrial fibrillation.

We also saw some posters to promote healthy eating and exercise entitled “EatDrinkKeepmoving”

The breast surgery team told us they held a health and wellbeing session that patients attended as their final appointment following breast cancer treatment to discuss diet, exercise, limb swelling and other relevant health topics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Consent was obtained in line with legislation and when patients did not have the capacity to make specific decisions, the principles of the Mental Capacity Act were followed for surgical procedures. DoLS applications were submitted to safeguard patients when necessary. When patients were unable to consent to their care, staff were able to describe how they acted in their best interests; however, nursing documentation of mental capacity assessments and best interest decision making was not always completed.

The trust had a consent policy based on national guidelines and recommended national consent forms were used. However, the policy was overdue for review, the review date being March 2018. The trust told us policies and procedures were being updated following the acquisition.

Staff told us the surgery, along with its potential risks and benefits were discussed at the outpatient visit and explained again on the day of admission. Most patients signed their consent form on the day of admission. This is not in line with current best practice guidance which states that consent should be gained prior to admission and re-visited on the day of surgery.

Staff gained written consent for interventions such as a blood transfusion and documented that verbal consent was gained, when patients were given treatments which did not require full written consent.

Patients we spoke with told us their treatment was discussed fully with them and the risks and benefits fully explained. They felt able to ask questions. They said that by the time they signed their consent form they felt fully informed.

We checked six consent forms and found they were correctly completed. When patients did not have the capacity to consent to the surgery, the correct consent form was used to record a mental capacity assessment and the best interest decision for the patient.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. We spoke with some medical staff and an advanced care practitioner who were able to describe the process for assessing a patient’s capacity and the best interest decision making process. Nursing staff, although being able to describe when a person lacked capacity and saying that decisions would be made in their best interests, described referring to medical staff or the mental health teams if a capacity assessment was required. Staff were under the impression that a referral to the mental health teams would lead to a capacity assessment if this was required.

However, we identified from two patient records that the mental health teams provided advice on the management of the patients, and they did not complete a mental capacity assessment. Mental capacity assessments are decision specific and therefore need to be made for each decision which needs to be made by the patient, if they lack capacity to make the decision themselves. We reviewed the care records of two patients with dementia or confusion and found interventions were carried out and no record was made of a mental capacity assessment or best interest decision. For example, in one case, the patient was recorded as being agitated and resisting care. On one occasion, it was documented that the person required a urinary catheter and staff were unable to gain their cooperation. The decision was made to delay the decision to the following day when it was hoped the patient would consent. The notes indicated that the person had a bladder scan and was catheterised the following day, although there was no documentation of consent; the patient’s confusion continued and they would not have been able to give valid consent. There were other examples of the patient refusing aspects of care, which were later provided. Although staff acted appropriately and gained the patient’s cooperation, and the care was in the person’s best interest, the documentation did not reflect this.

Staff were aware of the Deprivation of Liberty Safeguards (DoLS) which protect patients who are unable to make decision when they are in hospital and care homes. They identified that there were some occasions when a DoLS authorisation was necessary and told us there was a flow chart to follow to ensure the correct applications were made. We checked the records of a person who required a DoLS authorisation and found the application had been made appropriately.

**Mental Capacity Act and Deprivation of Liberty training completion**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust combines safeguarding level 2, mental capacity and deprivation of liberty (DOLs) training.

**Birmingham Heartlands Hospital**

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Birmingham Heartlands Hospital is shown below:
### Name of course | Number of staff trained | Number of eligible staff | Completion rate | Trust target | Met (Yes/No)
---|---|---|---|---|---
Safeguarding Level 2 Children and Adults/ DoLs and mental capacity | 295 | 297 | 99.3% | 90.0% | Yes

The trust’s 90% completion target was met for this module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in surgery at Birmingham Heartlands Hospital is shown below:

### Name of course | April 2017 to March 2018
---|---
**Name of course**

| Number of staff trained | Number of eligible staff | Completion rate | Trust target | Met (Yes/No)
---|---|---|---|---
Safeguarding level 2 children and adults/ DoLs and mental capacity | 212 | 247 | 85.8% | 90.0% | No

The trust’s 90% completion target was not met for this module.

### Is the service caring?

#### Compassionate care

**Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness. Staff maintained patients’ privacy and dignity and showed concern about their welfare.

Patients we spoke with commented positively about the kindness and compassion of the staff caring for them. They also commented on their attentiveness. For example, a patient said, “Nursing staff can’t do enough; they’re very kind. I feel as though I am in good hands.” Another patient said, “The carers do their best in difficult circumstances. They are very good with the elderly too.” A patient also commented on the interpersonal skills of a doctor. They said, “The doctor at night had a really good bedside manner; I felt ‘in his space’.”

We heard staff giving full explanations to patients and reassuring them. For example, we saw a member of staff in theatres hold a person’s hand, when they were having a cannula inserted. The patient relaxed and was laughing with the member of staff.

Staff explained ways they maintained patients’ privacy and dignity by drawing the curtains around the bed, speaking with them quietly where possible and keeping patients covered as much as they could when providing personal care.

We observed staff in theatres covering patients with a sheet and introducing themselves by name. When they transferred the patient onto the operating table, they maintained the person’s privacy and dignity when positioning them on the table and kept them covered.
In theatres, we found that all staff were friendly, approachable and very patient focused. This was witnessed when an emergency patient was bought in to theatres. The staff put the patient at ease. When the patient was being anaesthetised, the operating department practitioner acted as the patient’s advocate and reminded staff to be quiet.

**Friends and Family test performance**

**Birmingham Heartlands Hospital**

The Friends and Family Test response rate for surgery at the Birmingham Heartlands Hospital was 15.7%. A breakdown by ward is below (please note, only wards with at least 100 responses are shown).

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Responses</th>
<th>Response rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Apr-18</td>
</tr>
<tr>
<td>Day cases</td>
<td>827</td>
<td>11%</td>
<td>88%</td>
</tr>
<tr>
<td>Ward 11</td>
<td>220</td>
<td>43%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 5</td>
<td>166</td>
<td>33%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Staff told us they tried to obtain Friends and Family Test feedback from as many patients as possible and we saw friends and family test cards were displayed in all the ward areas.

Data from the ward quality dashboards included response rates and recommender scores for each ward. We saw that in August 2018, ward 4, ward 9 and ward 10 all obtained responses from between 38% and 66% of patients and the percentage of patients recommending the wards ranged from 94% to 96%. Ward 8 and ward 12 obtained responses from 20% of patient and the percentage or patients recommending the wards was 84% and 92% respectively.

The ward manager for ward 8 told us they struggled to obtain higher response rates due to the number of confused elderly patients; however, they told us they did prompt its use. Ward 12 had a high number of patients with a very short length of stay and this may have affected the response rate.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress. Patients were supported by ward staff and specialist nurses.**

Patients told us they received emotional support from nurses and other health professionals during their admission. Patients told us they found time for them when they were distressed or anxious and provided them with support and reassurance.

The trust employed clinical nurse specialists in a range of surgical specialties. These provided support to patients pre-operatively and post operatively. A patient told us of the emotional support provided to them from the colorectal clinical nurse specialist. They said they had needed time to come to terms with their diagnosis and the surgery required. They said the clinical nurse specialist was willing to help in any way they could. The patient told us the nurse specialist had met with them before surgery and was now visiting every day to support and teach them how to manage their colostomy. They had also been informed about self-help groups.
Another patient told us they had access to the thoracic nurse specialist by telephone and could contact them when needed.

The breast care specialist nurse saw patients prior to their admission for surgery and supported them through their journey. They were with the patient when they received their diagnosis and when discussing treatments. Patients were allocated a key worker to look after their welfare throughout each stage. The service had strong links with a local charity which supports women through their breast cancer treatment and could provide counselling for patients and their families. Other specialist nurses provided similar levels of support to patients.

A chaplaincy service was available offering a service to people of different faiths. The chaplaincy department also had a group of volunteers who carried out bedside visiting.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. Most patients were aware of plans for their care and treatment and said they had been provided with the information they needed to help them make decisions about their care. However, we spoke to three patients on one ward who felt there was a lack of communication between departments, which impacted on their ability to obtain information about the plan for their care.

Most patients we spoke with said they felt involved in the plan for their care and discharge and communication was good. A patient on ward 10 said their treatment options were fully explained to them and they knew the plan for their care. They said they had prepared them for the fact they would have a urinary catheter postoperatively and they had been taught how to manage the catheter.

A patient on ward 4 said they had been provided with information before they came into hospital and they felt they could ask questions then and also after their admission. They said they were able to ask the doctors questions when they came on the ward round and were fully involved in decision making. Another patient said they felt fully informed and had the opportunity to ask questions. They had been told they would go to the high dependency unit post-operatively and the doctors had talked to them about how their pain would be managed.

However, three patients on ward 11 told us they had extended waits for the results of their investigations such as ultrasounds and CT scans and they had difficulties finding out information. They said that although there were daily doctors ward rounds, the doctors didn’t talk to the patients and they felt unable to ask questions. One patient said, “I had an ultrasound two days ago and waited all day for the results, then they told me in three sentences.” Another patient said they had a CT scan the day before and they were still waiting for the results, to find out what treatment they needed. Another patient said they had received conflicting information from doctors and nurses and they had had to chase up their blood results. As a result, they did not know the plan for their care.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Following the acquisition the service was moving towards integration of surgical services, whilst considering local needs.

Average length of stay

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital

From March 2017 to February 2018 the average length of stay for surgical elective patients at Heartlands Hospital was 4.0 days, which was similar to the England average of 3.9 days.

Average lengths of stay for elective specialties:

- Average lengths of stay for elective patients in thoracic surgery was shorter than the England averages.
- Average length of stay for elective patients in urology was longer than the England average.
- Average length of stay in ear, nose and throat was similar to the England average.

Elective Average Length of Stay – Birmingham Heartlands Hospital

Note: Top three specialties for specific site based on count of activity.

Over the same period, for surgical non-elective patients, the average length of stay was 3.9 days, which was shorter than the England average of 4.9 days.

Average lengths of stay for non-elective specialties:

- Average length of stay for non-elective patients in general surgery was shorter than the England average.
- Average lengths of stay for non-elective patients in trauma and orthopaedics and urology were similar to the England averages.

**Non-Elective Average Length of Stay - Heartlands Hospital**

![Bar chart showing average lengths of stay for different specialties at Heartlands Hospital compared to England averages.](chart.png)

*Note: Top three specialties for specific site based on count of activity.*

(Source: Hospital Episode Statistics)

The senior leadership team were in the process of reviewing the provision of surgical services across the trust following the acquisition. They were considering the most appropriate configuration in terms of specialty surgical provision, that might be concentrated on one site, whilst maintaining local delivery of core surgical services to meet patient need. They were working with the local commissioners and other stakeholders in this process.

The trust was moving towards a provider alliance with a neighbouring trust specialising in orthopaedic surgery to improve orthopaedic referral to treatment times. They were working with this provider to develop a winter plan for the forthcoming winter period.

Vascular surgery was provided using the hub and spoke method, with specialist arterial surgery being undertaken at Heartlands hospital and other surgery being undertaken at the other hospital sites, to enable the routine care to be provided as close to the patients' home as possible.

The vascular team had introduced patient orientated assessments which were completed in one visit. Patients had their CT scan, cardio-pulmonary exercise testing, and saw the specialist nurse, anaesthetist and pre-operative nurse in one day. The following week, they were discussed at the MDT meeting prior to admission.

The service was working collaboratively with the local commissioners and other service providers to deliver an ophthalmology transformation plan, to improve ophthalmic care, reduce gaps in service provision and provide equality of access and treatment across the Birmingham and Solihull areas.

Surgical services were provided in an environment which, on the whole, was suitable for their needs. Wards were divided into single sex bays and there were a small number of side rooms that were mainly used for patients with infections. Bathrooms and toilets were designated as single sex, and the service was compliant with Department of Health guidance on single sex accommodation. The waiting room for the surgical assessment unit, had an information board, television and water machine for patients waiting for assessment.
Meeting people’s individual needs

The service took account of most patients’ individual needs. However, there was limited access to a face to face interpreter and important information was sometimes communicated by telephone. Staff awareness of the adjustments that could be made for patients with complex needs, was sometimes limited and wards did not have any adaptations to improve the experienced of people living with dementia.

The trust told us in their information return, that it provided comprehensive face to face, telephone interpreting services and written translation services. The services were provided through an external supplier and a small team of in-house interpreting services. The service was provided in all languages including British Sign Language and is available 24 hours a day, 365 days of the year. The in-house interpreting team acted as a hub for all interpreting and written translation booking requests and was based at Heartlands hospital.

Staff we spoke with told us they mostly used the telephone interpreting service. One member of staff said they sometimes had access to a doctor who spoke the person’s language, or they would try and obtain an official interpreter, but mostly the telephone service had to be used. Another person said, “A telephone interpreter is available, but it doesn’t work brilliantly.” Staff said this approach was the same when they needed to obtain consent from a patient. This is not considered to be best practice.

Staff told us that when caring for people living with dementia, there was a dementia nurse specialist, who could be contacted for advice if necessary and staff had received training in dementia. The trust reported there was no process in place to notify the specialist nurses of admissions, however the team took referrals for assistance and the assessment of complex patients with dementia.

Some of the wards we visited were caring for patients living with dementia. However, staff were not using any of the recognised schemes to alert staff and enable them to take this into account when caring for patients and communicating with them. Staff told us they used ‘twiddlemitts’ to calm patient’s anxiety and music could be played to aid relaxation; however, we did not observe this during the inspection.

When we asked about adjustments that could be made for patients with a learning disability, some staff said they weren’t aware of any, except that the patient’s carer could stay with them. However, on one ward, the ward manager said they would be nursed in a side room and a learning disabilities nurse could also be called, to ensure nothing was missed. They also explained how they had communicated with a deaf blind patient by using hand gestures and touch, with their consent. We also saw an information sheet displayed on ward 5 highlighting learning disabilities and the importance of clear communication.

The service provided bariatric surgery and staff told us equipment was available for bariatric patients. They had access to a service which provided special mattresses. Most bariatric patients were treated on ward 5 where there was the necessary equipment such as a hoist for transfer.

Dietary codes were used on white boards to identify patient’s dietary requirements such as vegan, diabetic, puree or gluten free meals. The service used the red tray system to identify patients who required assistance with their meals.

Access and flow
Patients could not always access the service when they needed it. Staff identified concerns with the management of emergency surgical patients and patient cancellations due to capacity and resource issues. This was apparent during the inspection. Cancellation rates for elective operations in the trust as a whole for the first quarter of 2018/19 were above the national average. However, waiting times from referral to treatment were approximately the same as the national average. The service had a plan in place for each specialty to improve referral to treatment times.

Referral to treatment (percentage within 18 weeks) - admitted performance

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>96.8%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>91.0%</td>
<td>60.4%</td>
</tr>
</tbody>
</table>
Plastic surgery | 90.4% | 81.2%
Urology | 83.6% | 76.8%
Ear, nose & throat | 75.0% | 62.4%
Ophthalmology | 72.7% | 68.5%

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>60.9%</td>
<td>70.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>57.4%</td>
<td>60.2%</td>
</tr>
</tbody>
</table>

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Five specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>98.2%</td>
<td>80.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>94.4%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.6%</td>
<td>77.4%</td>
</tr>
<tr>
<td>General surgery</td>
<td>75.4%</td>
<td>73.5%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat</td>
<td>74.9%</td>
<td>63.2%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>57.8%</td>
<td>69.6%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>43.4%</td>
<td>61.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The senior leadership team told us there had been a concerted effort to improve referral to treatment times. There were ongoing challenges in trauma and orthopaedics due to bed and theatre capacity and arrangements had been made with the private sector and a neighbouring NHS hospital to undertake some orthopaedic surgery. As a result of these actions, and action within the trust, the situation had improved over the summer and at the end of August 2018, the referral to treatment time had improved to 79%.

The trust had an overall action plan for referral to treatment times. Actions included ensuring maximum use of theatre capacity, including scheduling additional lists. There was an action plan in place for each specialty to address referral to treatment times and weekly meetings to review...
them along with confirm and challenge meetings. All patients waiting over 40 weeks were reported and escalated and harm reviews were completed.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Over the two years, this trust cancelled 3,440 surgeries. Of the 3,440 cancellations, the trust had a lower rate of patients not seen within 28 days than the England average for all quarters apart from July to September 2016 and October to December 2017.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - University Hospitals Birmingham NHS Foundation Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days](image)

**Cancelled Operations as a percentage of elective admissions - University Hospitals Birmingham NHS Foundation Trust**

![Graph showing cancelled operations as a percentage of elective admissions](image)
Over the two years, the percentage of cancelled operations at the trust showed was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From July 2016 to March 2018, this trust cancelled 2,326 surgeries. Of the 2,326 cancellations, the trust reported that 0% weren't treated within 28 days. This was consistently lower than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Heart of England NHS Foundation Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days]

**Cancelled Operations as a percentage of elective admissions - Heart of England NHS Foundation Trust**

From July 2016 to March 2018, the percentage of cancelled operations at the trust showed a rate consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.
During the inspection staff told us an operating list was cancelled that day, due to the volume of emergency admissions. We also heard that a patient was cancelled at 2.30pm as the previous patients had taken longer than expected and there would not be enough time to complete the surgery before the list finish time. We also heard about a similar situation during the inspection when a patient was cancelled at 3.30pm due to a lack of time to complete the surgery (the anaesthetist had another work commitment after 5pm). We also heard about a sick patient whose surgery was delayed that day due to lack of imaging staff. Staff told us about patients going to theatre when it was unclear as to whether a ward bed would be available after the surgery, resulting in delayed discharges from recovery. There was only one emergency surgical theatre to be used by general surgery, urology, vascular surgery, gynaecology, ENT and thoracic surgery. There was an all-day emergency surgical operating list planned for each Saturday. On a day we visited theatres, we were told there were six general surgical cases and three vascular cases for emergency surgery, all of which would not be able to be completed in the emergency theatre. We were also told that the previous Friday there were 31 patients waiting for surgery to be carried out over the weekend. A member of staff told us that the policy was to cancel an elective list when there were 14 or more hours of emergency surgery waiting. A meeting was held each morning, between the anaesthetist and the consultants, to agree the priorities for the emergency theatre that day. This meant some emergency patients were unable to access surgery in a timely way. This had the potential to adversely affect patient outcomes.

Following the inspection, the trust told us that 90 theatre sessions were cancelled from October 2017 to September 2018. The two most common reason for cancellation were no surgeon available and site pressures.

Staff told us the volume of emergency surgery had increased over recent months and there were frequently between 40 and 60 patients per day, attending the surgical assessment unit. Staff in the surgical admissions unit told us the two triage rooms could not always be used for triage, as they had to be used for patients staying overnight. We witnessed some of the capacity pressures and resulting communication problems, when a patient was brought to a surgical ward in a wheelchair by the site team. They told the staff the patient was to go into the side room. However, a patient was still in the side room, waiting to be told the outcome of their investigations (we had spoken with them a few minutes before) and they were not aware they were being discharged. The site team left the patient in the wheelchair outside the room.

Staff in the day surgery unit said the unit was used as an escalation area when necessary and sometimes patients were cared for on the unit overnight. This lead to cancellations. We were told elective patients were cancelled the evening prior to their admission when this occurred.

Staff told us patients who were medically fit for discharge, were frequently delayed when they required a care package or transfer to another care provider. A member of staff said that on the trauma and orthopaedic wards, approximately 50% of patients were medically fit for discharge. A discharge hub managed new packages of care and transfers of care and there were daily meetings to review patients and expedite discharge. A supported integrated discharge team was in place in the community and we were told they sometimes accepted patients waiting for a package of care.

When patients were discharged, staff completed discharge summaries to inform general practitioners (GPs) about the patient’s admission and treatment. These were sent to the patient’s GP electronically and a copy was given to the patient to take home with them.

**Learning from complaints and concerns**
The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with all staff. However, complaints were not always closed within the 30 working day timeframe stipulated in the trust complaints policy.

The trust had a complaints policy and a complaints and Patient Advice and Liaison Service (PALS) team. We saw some information about these was available in the clinical areas.

**Summary of complaints**

**Trust level**

From April 2017 to March 2018 there were 188 complaints about surgery across the trust as a whole. The trust took an average of 38.8 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Of the ten complaints still open at the time of reporting, all had been open longer than the trust’s target of 30 working days, with the longest being open for 252 working days.

A breakdown by site is below:

- **Queen Elizabeth Hospital**: There were 118 complaints, the main themes were clinical treatment with 35 complaints (29.7%), patient care including nutrition / hydration with 25 complaints (21.2%), staff with 16 complaints (13.6%), admissions, discharges and transfers with 15 complaints (12.7%) and communications with 15 complaints (12.7%).

- **Birmingham Heartlands Hospital**: There were 39 complaints, the main themes were all aspects of clinical treatment with 25 complaints (64.1%) and admissions, discharge and transfer arrangements with six complaints (15.4%).

- **Good Hope Hospital**: There were 20 complaints, the main theme was all aspects of clinical treatment with 11 complaints (55.0%).

- **Solihull Hospital**: There were 11 complaints, the main themes were all aspects of clinical treatment with three complaints (27.3%), appointments, delay/cancellation (in-patient) with three complaints (27.3%) and communication/information to patients (written and oral) with two complaints (18.2%).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 627 compliments within surgery.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>490</td>
<td>78.1%</td>
</tr>
<tr>
<td>Nuffield House</td>
<td>119</td>
<td>19.0%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>12</td>
<td>1.9%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>3</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
Patients we spoke with were not always aware of how to make a complaint, however, they told us they would speak to the person in charge of the ward. We observed some information about the complaints and PALS service was available near the entrance to wards and in the corridors.

Ward managers were generally aware of the complaints for their ward and told us they tried to address any issues and communicated concerns to staff at daily handover. One ward manager said they had only had two complaints in the last twelve months; they said that when issues were highlighted by staff, they talked with the patient and dealt with it immediately, to avoid it becoming a bigger issue. Another ward manager said they put a copy of the complaint letter, response and action plan on display in the staff room to ensure staff were aware of the actions.

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, matron and manager support to individual wards and the operating theatres was variable.

The senior leadership and management team for surgical services at Solihull hospital also managed surgical services at Birmingham Heartlands hospital and Good Hope hospital. Most surgical specialties were within division 5; however, theatres, anaesthetics, day case and ambulatory surgery were managed separately within the clinical support services division (division 1). Each team was led by a divisional director, director of operations, finance manager and head of nursing. The head of nursing was supported by matrons who had responsibility for specific specialties and also covered more than one hospital site.

We spoke with the divisional directors and head of nursing for division 5 and other members of the corporate management team. We found they had a good grasp of the issues and challenges facing the service and were working together to take forward improvements. However, the fact that theatres, anaesthetics and day surgery were managed in a different division meant there were separate lines of responsibility and there was not always someone with the overall picture. We did not see examples of joint meetings between theatres and wards that we have seen in other trusts. However, there were collaborative relationships between the wards and theatres and day surgery and no evidence of specific difficulties.

Senior sisters told us the matrons were supportive and always available on the telephone. However, the amount of time the matrons spent on site and therefore in the clinical areas was variable. Some staff reported seeing their matron most weekdays, while others told us their matron was not based on site and they saw them once a week. Some staff said the divisional matron covering staffing also walked the wards; however, others said staffing issues were dealt with over the telephone. On ward 11, some staff expressed a concern that they did not see their matron frequently and one nurse said they didn’t know their matron and had never been introduced. They felt that managers did not know the extent of the challenges on the ward and looked at the situation from a computer. Nursing staff told us it was unusual to see divisional and other senior managers on the wards and one person commented that they met with the consultants but not with other staff. The matron for theatres also covered theatres across their division and therefore

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>0.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total</td>
<td>627</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
visited the theatres infrequently. Theatre staff reported they saw more senior managers very infrequently. One person said they only saw them when there was an incident or a bed crisis.

Division 5 band seven meetings were held to share practice and discuss improvements. Band seven staff told us they had met with the new chief nurse the previous week. They were optimistic about future communication and felt the chief nurse would ‘pull things together’.

Senior ward sisters were aware of their ward’s performance in relation to the quality metrics measured on a monthly basis, the percentage of staff who had completed mandatory training and their appraisal rates. They showed good leadership skills and staff told us they were supportive, helpful and flexible.

The senior sisters did not hold regular team or staff meetings on most wards. One ward manager told us that they had a ‘message of the day’ at handover, and others described daily huddles to communicate information.

Senior sisters were given some supernumery shifts to carry out their managerial and supervisory role and on other days worked clinically. In theatres, there was no supernumery coordinator and the theatre band seven staff also acted as the coordinator and also worked clinically. This reduced the time available to act in a supervisory capacity and oversee the quality of care.

**Vision and strategy**

Staff were aware of the trust’s vision to, “Build healthier lives.”

The main focus going forward following the acquisition was the full integration of surgical services across the trust to create a single division for surgery. Progress was being made specialty by specialty and managers told us vascular, plastics, urology, and upper gastro-intestinal surgery were leading on this. Therefore, the strategy was based on further integration of services.

Although many of the policies and processes for the Birmingham Heartlands, Good Hope and Solihull sites were separate from those for the Queen Elizabeth Hospital, work was being undertaken to integrate these.

**Culture**

The culture at clinical level was open and positive and there was a sense of common purpose based on shared values. However, we received some feedback about differences in the culture between the Queen Elizabeth hospital and the former Heart of England NHS trust hospitals. The short period of time since the acquisition meant that some staff felt it still functioned as two different trusts.

Most staff were positive about the acquisition and thought it would bring benefits to everyone. One member of staff commented that safety was the main priority across the whole trust and this was positive. However, some staff said they felt it was more hierarchical than previously and it was more difficult to achieve agreement to change. One person said the Queen Elizabeth approach was process driven and lengthy. They spoke about ‘command and control’ and a rule based culture. Some staff felt managers did not listen when they raised concerns about workload and staffing levels.

At clinical level staff spoke about very close team working and working together to overcome issues and challenges on a daily basis. All the teams we spoke with were proud of their ward or department and were patient focused.

Most staff were aware of who the trust’s freedom to speak up guardian was. The role of the freedom to speak up guardian is to ensure that staff have the capability to speak up effectively and are supported appropriately.
Governance

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. We found examples of discussion at specialty and divisional level to identify improvements to the quality, safety and effectiveness of care.

However, there was little engagement or understanding of governance issues below band seven level.

Surgical services had an established clinical governance framework at divisional and specialty levels. At divisional level there was a quality and safety committee that met monthly and directorates reported to this committee. We reviewed the minutes of a meeting and found there was good attendance from clinical directors, governance leads, matrons, and the senior management and leadership team for the division. There was a structured agenda with discussion of risks, incidents complaints and reports from each specialty governance group.

We reviewed the minutes of clinical governance meetings held at specialty level and whilst the agenda was not consistent across the different specialties, there was evidence of a discussion of incidents, risks, audits and ongoing operational challenges to the quality of the services. Each specialty had a nominated audit or governance lead. There was good attendance at most meetings although we noted that in most cases junior doctors and ward sisters were not in attendance. We spoke with senior sisters and they told us they did not attend clinical governance meetings, however, the matrons cascaded information from governance meetings at their divisional band seven meetings.

Theatres, anaesthetics and day surgery held audit days on a quarterly basis when elective surgery was suspended and a planned programme of presentations and discussions took place in relation to learning from clinical audits and incidents and training was provided.

Divisional band seven meetings were led by the divisional head nurse and these focused on quality improvement initiatives, learning from others and sharing good practice. However, there was little engagement or understanding of governance issues below band seven level.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risks were clearly identified in the divisional risk registers.

Divisional risk registers identified the key risks within each division. We reviewed the risk registers and found the risks we had identified during the inspection were generally identified on the risk register. Minutes of the specialty governance meetings showed that risks for each specialty were identified and reviewed. Risks associated with junior medical staffing were identified in most specialties, however, actions to mitigate the risks were identified and we noted that in some specialties these issues had reduced. Nurse staffing was also identified as a risk on the risk register and actions were being taken to address these through an ongoing recruitment programme and the development of associate practitioners. Risks related to insufficient surgical bed capacity were identified in most specialties and had remained on the risk register for over two years. However, the senior leadership team told us they were looking at how they could maximise the use of the surgical beds at Solihull hospital where elective surgery was undertaken. The hospital was mainly utilised for short stay and day case surgery and there was limited access to high dependency care and out of hours medical cover. A risk associated with surgical bed capacity was identified and senior managers told us they were looking at re-modelling beds. However, a
specific risk about the volume of general surgery emergency patients and emergency theatre capacity in relation to this was not identified.

Nursing quality metrics were measured and reported on a monthly basis. Matrons from another area completed the audits to ensure independence. The metrics covered a wide range of quality indicators including number of pressure ulcers and falls, VTE assessment, medicines management, patient safety and dignity, nutritional assessment, observations and manual handling. Ward managers were aware of their monthly performance in the metrics and told us they had one to one feedback in relation to their performance. They told us of actions they were taking to improve, including daily spot checks of specific aspects of documentation such as fluid balance charts and highlighting issues to staff at handover or with written reminders. All the surgical wards had their quality indicators displayed for patients, visitors and staff to see.

Root cause analysis (RCA) was completed for hospital acquired grade 3 and 4 pressure ulcers and injurious falls. Senior sisters told us they completed an investigation and a checklist on the electronic incident reporting system to identify whether all preventative measures were in place prior to the incident. They said the falls specialist nurse or the tissue viability nurse reviewed the investigation and together agreed whether it was avoidable.

The division showed evidence of a planned approach to clinical audit in that each specialty had an audit plan for 2018/19 and monitored progress against it.

**Information management**

*The trust collected, analysed, managed and used information well to support its activities. Most records were paper based and when electronic systems were used, security safeguards were in place.*

The service effectively used the information gained from data collection and audits to challenge and improve practice. We saw evidence of the escalation of issues to the quality and safety committee when required.

Medical records relating to each patient’s current admission in ward areas were paper based and stored in lockable trolleys on the wards. During the inspection we found that these trolleys were locked in accordance with requirements. Nursing daily records of care such as vital signs observations and food and fluid balance charts were stored at the end of each patient’s bed.

Wards had white boards identifying the names of patients in each bed although there was no other information about the patient such as their diagnosis.

Computers used on the wards to access patient information, such as results of investigations, discharge letters and medicines systems, were always logged out when we observed them unattended, thus protecting patient information.

Trust policies and clinical guidelines were available on the trust intranet. Some staff told us they found it easy to access policies and guidelines whilst others told us they had experienced difficulties in finding particular policies.

**Engagement**

The trust reported that in the 2017 national staff survey the Heart of England NHS Foundation trust scored within the bottom 20% of trusts for staff recommending the trust for work and for treatment. These scores showed a small improvement as compared to the previous year. The number of staff receiving an appraisal was 90%, which is in the top 20% of trusts.
During the inspection we found staff showed an enthusiasm for their work and a commitment to providing a high quality of care. They told us communication at ward level was good and there was good team working. Staff told us they did not always hear about changes in the trust and trust emails were their main form of information. Staff viewed the acquisition as an opportunity to share good practice and learn from others.

There were divisional band seven meetings that staff found useful to share practice and keep abreast of developments in the trust. However senior sisters told us the trust band seven meetings had not been held for some time. They said they had raised this with the director of nursing and they had suggested the senior sisters took the lead and coordinated the meetings.

A counselling service was available for staff which received positive feedback.

The trust had a patient and carer council, that were consulted on a number of trust wide initiatives. They were involved in a discussion about the new ambulatory care and diagnostics building at Heartlands hospital and were involved in the patient led assessments of the hospital environment.

We found a range of information available for patients and relatives about the friends and family test and feedback they had received. This also described actions taken to further improve and act on suggestions made.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Senior medical staff for trauma and orthopaedics said they had a plan to re-configure services over the next four years, to achieve separation of trauma and elective orthopaedic services. They told us one of the key issues were the lack of intensive care facilities at Solihull hospital.

The trust gave us examples of two areas in which they were providing innovative practice at Solihull hospital and Heartlands hospital. These were urolift surgery in patients with a benign enlarged prostate and the prostate clinical pathway.

Student nurses gave us very positive feedback on the quality of the learning environment on the wards and day procedures unit at Solihull hospital and the amount of support they received. This made them more likely to want to return to the hospital when they qualified. The senior sister on ward 15 and 16 said they had been nominated by student nurses for their teaching.

A high proportion of patients in surgery were treated as day cases, reducing the disruption to patient’s daily lives.

The division had a process in place for learning from deaths. Morbidity and mortality review meetings were held for each specialty. Staff and managers told us there was a constructive learning atmosphere at the meetings. We reviewed the notes of a sample of mortality and morbidity meetings and saw there was a full discussion of each case and learning points were identified.
Maternity

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Maternity services have been provided by University Hospitals Birmingham NHS Foundation Trust from April 2018. Prior to this date they were provided by Heart of England NHS Foundation Trust.

The trust has 145 maternity beds across three sites:

Good Hope Hospital
- Delivery suite – 20 beds plus two pool rooms and a high dependency bed
- Ward 4 – 11 beds, mix of induction and inpatient
- Ward 5 – 22 postnatal beds

Birmingham Heartlands Hospital
- Aspen Ward – 19 inpatient beds plus seven transitional care beds
- Delivery suite – 13 beds, including two high dependency beds plus six induction beds
- Cedar Ward – 19 postnatal beds
- Maple Ward – 26 postnatal beds
- Willow Ward – 3 birth beds
- Eden Ward – bereavement suite with two beds and a sitting room.

Solihull Hospital
- Three birth rooms
- Two postnatal rooms

Queen Elizabeth Hospital does not provide any maternity services.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provides consultant led, midwifery led stand alone and alongside units. In addition, there are teams of specialist and community midwives who care for women during their pregnancy and post-natal period.

The trust has maternity services on three sites therefore there will be some similarities within the three reports.

The trust reported that their maternity services are working closely with local specialist trusts in the Birmingham & Solihull United Maternity and Newborn Partnership (BUMP) project looking at access, choice and continuity of care across the organisations.
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From April 2017 to March 2018 there were 9,348 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Heart of England NHS Foundation Trust – Comparison with other trusts in England

(Source: Hospital Episodes Statistics)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Heart of England NHS Foundation Trust by quarter
(Source: Hospital Episode Statistics)
By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory Training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

All staff working within maternity were required to complete the trust mandatory training modules on an annual basis for example fire, information governance and counter fraud.

Multi-disciplinary emergency simulation training was compulsory by all midwives and obstetric staff including consultants and anaesthetists. Staff told us there were plans to also make the training compulsory for maternity support workers.

Midwives were required to complete an additional study day which covered relevant and current topics, for example suturing, caring for women with epidural anaesthesia and medical gas safety.

**Mandatory training completion rates**

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified staff in maternity at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>255</td>
<td>256</td>
<td>99.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>254</td>
<td>256</td>
<td>99.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>253</td>
<td>255</td>
<td>99.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>251</td>
<td>256</td>
<td>98.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management</td>
<td>248</td>
<td>256</td>
<td>96.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>248</td>
<td>256</td>
<td>96.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>246</td>
<td>256</td>
<td>96.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>236</td>
<td>256</td>
<td>92.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>231</td>
<td>256</td>
<td>90.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>228</td>
<td>256</td>
<td>89.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>220</td>
<td>256</td>
<td>85.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>219</td>
<td>255</td>
<td>85.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall training compliance rate of 94.1% for qualified staff. The trust’s 90% completion target was met for nine of the 12 mandatory training modules for which qualified staff were eligible. The resuscitation - clinical module had the lowest completion rate, at 85.9%.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in maternity at Birmingham Heartlands Hospital is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention and control</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>37</td>
<td>37</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>34</td>
<td>37</td>
<td>91.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>31</td>
<td>38</td>
<td>81.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>28</td>
<td>37</td>
<td>75.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>28</td>
<td>37</td>
<td>75.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>28</td>
<td>37</td>
<td>75.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>25</td>
<td>37</td>
<td>67.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>24</td>
<td>37</td>
<td>64.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Waste management</td>
<td>23</td>
<td>37</td>
<td>62.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall training compliance rate of 82.9% for medical staff. The trust’s 90% completion target was met for five of the 12 mandatory training modules for which medical staff were eligible. The waste management module had the lowest completion rate, at 62.2%.

The staff we spoke with on inspection who were responsible for training provided data on the current compliance with mandatory training as of the end of September 2018. The data was trust wide, and was not available split by site.

The compliance with basic life support, including the use of automated external defibrillators (AED), (487 staff out of a total of 587) was 83% with a further 50 staff booked to attend. The compliance with training for blood collection was 95%.

Compliance with emergency skills training was 100% for consultants, 96% for junior doctors and 94.3% for midwives. The compliance rate for midwives included specialist midwives and managers who had direct contact with women and were included in the staffing escalation plans but did not include staff on maternity leave or on long term sickness.

Anaesthetists working within maternity were required to attend emergency skills days bi-annually, providing they attended other emergency study days, for example airway management but staff acknowledged it was difficult to obtain good compliance with this staff group. Training staff had escalated this through the governance process and current compliance was 64%, an increase of the previous year of 55%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding
Staff understood how to protect women 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.

The safeguarding team are managed by the head nurse for safeguarding who reports to the Chief Nurse as the executive lead for safeguarding, providing board oversight of safeguarding arrangements. Policies, procedures, protocols and frameworks relating to safeguarding were in line with national guidance and staff told us they were easily accessible.

There was a trust wide, band 8 named midwife for safeguarding, who worked closely with other members of the corporate safeguarding team. The trust had band 7 specialist midwives for women in vulnerable circumstances who had responsibilities for safeguarding within their role. This included specialist midwives for women with perinatal mental health concerns, those who experienced substance misuse or domestic abuse, those who were homeless, refugees or asylum seekers, women who were teenagers or who had experienced female genital mutilation. Specialist midwives supported staff to provide care in partnership with other agencies to ensure women were helped, supported and protected.

All community midwives received clinical supervision in group sessions and as individuals on an ad hoc basis as required.

We saw the electronic record had sections and flags that highlighted any social plans in place. We were told of occasions in the past where information was not correctly recorded on the electronic system, and lessons were learned from these incidents and processes improved. The electronic record did not currently share information about the mother with babies on the neonatal unit and staff were working with the provider of the electronic system to resolve this issue.

The service had clear guidelines for staff to use when women presented unbooked either late in the pregnancy or in labour. These guidelines included the identification of women with safeguarding concerns who may be deliberately avoiding healthcare professionals.

Clinical staff working with children, young people and/or their parents received training at level 3, in line with national guidance. This training included an awareness of Child Sexual Exploitation (CSE), modern day slavery and female genital mutilation (FGM) and outlined responsibilities for reporting and referring cases identified. The trust had an FGM guideline to support staff with this. In 2017 the trust reported two identified cases of FGM to the Health and Social Care Information Centre (HSCIC), in line with the statutory guidance by the Department of Health in 2016 for all organisations. The service implemented the FGM Risk Indicator System (RIS) in May 2018. This is a system that flags children deemed to be at high risk of FGM and includes mandatory referrals.

There was an FGM ‘champion’ who provide support and training to staff within maternity and other core services. For example, during our inspection of the Emergency Department, staff working there reported they found the FGM support and training very valuable.

During our inspection we saw staff on the delivery suite identify and take appropriate action whilst caring for a woman with FGM. We saw they understood their responsibilities toward safeguarding the unborn child.

The trust had a baby abduction policy and staff told us that the service used an electronic tag system for babies which meant that the risk of babies being abducted was minimised. Service leads told us the abduction policy was tested across all the site and another exercise was being planned.

Safeguarding training completion rates
A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in maternity at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>255</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall safeguarding training compliance rate of 99.6% for qualified nursing staff. The trust’s 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in maternity at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>34</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>13</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall safeguarding training compliance rate of 85.5% for medical staff. The trust’s 90% completion target was met for one of the two safeguarding training modules for which medical staff were eligible.

Staff told us they completed safeguarding levels 1, 2 and 3 depending on their clinical role. Face to face training was provided for levels 2 and 3. Data obtained from staff during the inspection showed 88.1% of all staff had completed their required level of safeguarding training up to the end of September 2018. We were told 96% of midwives had completed level 3 safeguarding training and the corporate training team was responsible for ensuring medical staff compliance with training. A further 50 staff were booked onto the training for the quarter up to the end of December. The trust was unable to further split the data by site or clinical role.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff kept themselves clean but did not always keep equipment and the premises clean.
The systems in place to prevent and protect people from the risk of a healthcare-associated infection were not robust.

Staff had access to a range of infection prevention and control policies, procedures and guidelines, which were available on the trust’s intranet site. We saw staff adhere to policies in relation to hand hygiene and infection control. For example, we saw staff observed the ‘bare below the elbow’ rule and did not wear watches or jewellery in clinical areas. However, we did see some notice boards that were not ‘wipe clean’.

Although all areas had cleaning records which were dated and signed by housekeeping staff, we observed some clinical areas were not visibly clean. For example, we found one bed on the delivery suite had been recently cleaned and ready for use by the next woman, however we saw large areas of contamination with bodily fluids. We observed one patient shower cubicle on a postnatal ward had recently been cleaned by housekeeping staff, however we saw a large area of mould or mildew that inspection staff were able to wipe away. We saw a range equipment in use such as blood pressure monitoring equipment which was not visibly clean and we saw equipment used to monitor baby wellbeing were contaminated with gel, even though there were labelled with a “I am Clean” green sticker. We saw the clean utility room on a postnatal ward was not visibly clean, with splashes on the walls and worksurfaces, and the medicines cupboard was sticky and dirty. We escalated our concerns to senior staff for these areas and we saw they were immediately rectified.

Some of the cleaning staff we spoke with told us they only cleaned the environment and the non-medical equipment. They told us there was low morale amongst that staff group because of low staffing and pressure of work. Maternity support workers cleaned the clinical equipment and beds in between use.

The trust provided details of environmental audits for the maternity unit. For the three months prior to 29 October 2018, we saw the self-audit scores for all the wards at Heartlands Hospital were above 95%. The infection prevention and control team had audited Maple ward in June 2018 and the Delivery Suite in September 2018 and the scores were 99% and 93% respectively. However, in view of our findings on inspection, we were not assured this audit process was robust.

We requested data from the trust for all infections and readmissions across all the maternity service, however the data we received was limited and did not include puerperal sepsis or other infections. This data was also not included on the obstetric dashboard. Data provided by the trust for the six-month period from April to September 2018 showed one maternal infection with E-Coli (pre 48 hour). Data provided within the report to the Obstetrics Quality and Safety group from July 2018 showed, from April to August 2017, the surgical site infection (SSI) rate for women across the trust averaged 18%. The lowest rate was 12.5% in May and the highest was 22.7% in August. The England average for SSI was 9.6%. We saw this was one of the quality improvement workstreams.

Staff had access to and used suitable personal protection clothing such as gloves, aprons and face guards to protect people from a healthcare associated infection.

There was a sufficient supply of hand sanitising gels and sinks throughout the clinical area with handwashing prompts for staff, women and visitors. We saw hand hygiene audit data displayed on the maternity unit. For 2018 to date, staff on all areas were at least 95% compliant, apart from Maple Ward which was 87.5% compliant.

Some areas had disposable curtains and we saw the curtains looked visibly clean and had dates written on them to remind staff when they needed to be replaced.
Environment and equipment

The service did not have adequate premises however did have adequate equipment. Staff mostly looked after equipment well.

The maternity unit at Heartlands Hospital was situated in a purpose-built building however it pre-dated the Department of Health’s recommendation that birthing rooms should include en-suite facilities (DH Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities, 2013.) Most of the delivery suite rooms did not have en-suite facilities. Of the three rooms in the Willow alongside maternity led unit (MLU), two were en-suite whilst the third and smallest had not en-suite facilities. Staff told us this room was more often used for postnatal care or as an antenatal clinic room where ever possible. The maternity wards, delivery suite, MLU and neonatal unit were housed in the same building.

The building had been designed to accommodate fewer births than the current number and we saw the clinical areas were overcrowded and cluttered, with limited storage for equipment. There were limited waiting areas for women whilst waiting to be seen in antenatal clinic and Pregnancy Assessment Emergency Room (PAER). The safe management of women attending PAER had been on the Obstetric risk profile since April 2016. We saw there was limited space within PAER, this meant it was difficult for staff to maintain confidentiality for women whilst being monitored or assessed. Community midwives told us their administration office was very small, with space for three staff to work electronically, however approximately 60 community staff were employed and we were told this was frustrating when staff needed to access electronic records.

During our inspection, we heard from service leads that the trust had approved plan to renovate the unit, mainly using charitable funds and this would improve the environment for women, visitors and staff.

All the elective caesarean sections for the whole maternity service were performed at the Heartlands hospital. There was a dedicated elective caesarean section list, which was not carried out in the obstetric theatres on the delivery suite, but in another theatre nearby. This meant there was always two obstetric theatres available for emergencies.

Emergency and essential equipment was easily accessible and mostly checked daily in accordance with the trust’s policy. Adult and neonatal resuscitation equipment, including the resuscitaires, in all areas were checked daily. Resuscitaires are used as a warming therapy platform with facilities for managing a clinical emergency in a new-born baby. However, we saw the anaesthetic machines in the obstetric emergency theatres were not always signed to confirm they had been checked daily. From 10 September 2018 to 17 October 2018 we saw there were 13 missing signatures from the main theatre and 15 missing signatures in the back up theatre. This meant there was not always assurance the equipment would be immediately available for use in an emergency. There were no sepsis boxes, however staff told us and we saw equipment and supplies required for the early treatment of sepsis were readily available in the clinical areas. (Sepsis is a life-threatening illness caused by the body's response to illness.)

We saw there were daily task signature sheets in most areas, to ensure essential tasks were completed daily, for example fridge temperature and equipment stock checks. We saw there was inconsistent completion of this task sheet, for example in the PAER there were eight days in August and nine in September where there were missing signatures. However, we saw staff completed temperature checks daily for the fridges in all areas and signed a checklist by the fridges to confirm they had been checked and any action taken in the event of temperature being...
outside of the acceptable range. We saw a new checking sheet was introduced during our inspection.

Cardiotocography (CTG) machines were available for women who required continuous electronic fetal heart monitoring. A CTG machine is used to record both the baby’s heart rate and uterine contractions during pregnancy and labour. Its purpose is to monitor the baby’s wellbeing and allow early detection of distress. Staff were also able to directly monitor the baby’s heart rate in labour using a fetal scalp electrode (FSE). This is a device which is attached to the top of the baby’s head and provides a more accurate picture of the baby’s heart rate.

An intercom and buzzer system was used to gain entry to the delivery suite and maternity wards and the Maternity Ward to identify visitors and staff so that women and their babies were protected from avoidable harm. Exit was not controlled; staff and visitors could exit by pressing a door release button. However, we learned of an incident that occurred in August 2018, where a member of the public gained entrance to the delivery suite and was found asleep in a bed. Managers told us other members of the public authorised to enter the area had allowed them to ‘tailgate’ through the door. In addition, there was no receptionist on duty that day, who would have challenged the authorised person. No additional security measures had been implemented. to date.

There were birthing pools on delivery suite and on the MLU, which were clean and well maintained, and there were nets to evacuate a woman from the pool in an emergency.

We examined 24 pieces of equipment. Most of the equipment had a recent service testing or medical engineering date. This meant that equipment was maintained in line with relevant safety standard and staff could be assured it was safe to use.

We made random checks on sterile single use equipment such as syringes, blood bottles and needles and found most had intact packaging and were within expiry dates.

Suitable arrangements were in place for the management of clinical specimens and waste disposal. Clinical waste bins were emptied regularly and contaminated sharps were segregated according to their nature.

**Medicines**

The service mostly followed best practice when prescribing, giving, recording and storing medicines. Most women received the right medication at the right dose at the right time.

Staff mostly prescribed, administered and supplied medicines to women and babies in line with relevant legislation, current national guidance and best available evidence.

We checked drug cupboards and ward trolleys and found them to be locked and secure. The temperature of fridges used to store medicines was regularly checked. This meant staff could be assured that medicines were being stored at the correct temperature. Most intravenous fluids were stored in locked rooms in all areas this minimised the risk of them being tampered with. We saw emergency drugs and fluids were stored with other emergency equipment which was not locked away, in line with guidance from the Resuscitation Council UK. However, we saw not all emergency drugs and fluids were stored in tamper evident containers or wrapping, which is not in line with guidance. We escalated this to senior staff who gave assurance it would be rectified.

Controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001), were stored appropriately in a locked cupboard and the keys held separately from the main keys. We checked the physical stock of the CDs against the stock level recorded in the register and saw evidence of daily checking by two midwives in each clinical area.
Staff told us the trust’s medicines policy included guidance for use of medicines within the operating theatres. The guidance stated some emergency drugs could be pre-drawn by the anaesthetist at the start of the shift, however they should be clearly labelled, dated and signed and to be disposed of if unused at the end of the shift. We saw emergency drugs had been pre-drawn and were labelled but there was no date or signature on the syringes. This meant staff would not know who had drawn up the medicines or how long it had been there. We highlighted this to theatre staff who removed the pre-drawn medicine.

The hospital used paper prescription and medication administration record charts for women. We looked at five prescription charts. Of the charts we looked at we saw most did not have the woman’s name recorded on every page of the chart and the prescriber’s signature was not always legible. We saw one prescription chart where paracetamol had been written but the prescriber had not signed the chart which meant the medicines had not been correctly prescribed, however we saw the medicine had been administered on several occasions to the woman.

Staff recorded women’s allergies on the prescription chart. The records showed women were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. These meant women were receiving their medicines as prescribed.

**Records**

Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The trust used a combination of paper and electronic records for women who used the maternity service. Most of the woman’s care was recorded electronically however standardised notes developed by the Perinatal Institute were used for intrapartum care. Service leads told us there was a plan for all records to be kept electronically by Spring 2019. One of the key deliverable outcomes of the Birmingham & Solihull United Maternity and Newborn Partnership (BUMP) was for ‘all women would have a single, electronic personalised care plan that they have full access to by December 2018’. We reviewed the bi-monthly progress of BUMP and saw they were on track to meet this milestone.

Service leads told us an order to supply additional computer equipment for community midwives had been approved, which would make it easier for them to access women’s records when working away from the hospital.

Women who lived out of the area but were booked to give birth in the trust, were given hand held records by the community midwives in that area, which were then input into the electronic system. This meant there was an inconsistent but unavoidable use of paper records. We saw this caused a degree of confusion to staff because of the combined use of computerised notes and written records.

We reviewed 10 sets of records across the two obstetric units, at Heartlands Hospital and Good Hope Hospital. Women’s individual care records were written and managed in a way that kept them protected from avoidable harm. Information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way. Staff mostly stored medical records securely in restricted areas or in lockable trolleys in line with data protection policies. However, we did see records not stored securely in the PAER and staff did not always follow good information governance practices and left computer screens unlocked meaning confidential patient information might be accessed by unauthorised people.
A summary of care was included in the postnatal notes for the community midwife following discharge from hospital. A discharge summary was included in the notes to be sent to the GP and health visitor prior to discharge from the community midwife.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each woman. They kept clear records and asked for support when necessary, however assessments were not always in line with local policies.

During the initial booking appointment, midwives took a comprehensive medical, obstetric and family history from women. The booking record was kept electronically and pregnant women were given a summary of their antenatal care to keep with them, including a copy of any ultrasound scan report. As part of the initial booking, midwives also made assessments including social concerns, tobacco, drug and alcohol use and a mental health assessment using a recognised assessment tool.

Assessments of venous thromboembolism and of immunisation history were also recorded. Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most common in a leg vein, where it is known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE). The service audited compliance with the trust’s VTE screening tool. From our review of the minutes of the Obstetrics and Gynaecology Quality and Safety meeting in October 2018, compliance was 98.42%.

These assessments, together with the medical and obstetric history, was used to classify the woman as ‘low’ or ‘high’ risk. Low risk women continued with midwifery-led care, whilst high risk women were referred to consultant-led care.

A team of midwives reviewed all the booking assessments to ensure women were seen by the most appropriate professional, which might be a consultant obstetrician, anaesthetist or specialist midwife.

At each antenatal appointment women’s individual risks were reviewed and reassessed. Women across the trust choosing to give birth at one of the midwife led units (MLU) or planning a home birth, were offered a place of birth antenatal assessment at 36 weeks of pregnancy, to determine if they were still suitable. Staff put stickers in the woman’s hand-held notes to alert staff on the delivery suite of the woman’s birth plans, which would prompt them to redirect her to the MLU. Only women risk assessed as low risk could usually birth their baby at the birth unit or within their own home.

Women with identified with high risks would be advised to birth their baby at the consultant led unit. However, we saw midwives and obstetricians worked together to create a care plan for women assessed as high risk who declined to plan the birth of their baby on the obstetric-led delivery suite, as this would be a lower risk option than birthing at home against advice. The plan was communicated to all MLU staff who signed to confirm they had read it. When the woman arrived at the MLU the on-call consultant obstetrician was informed and would be ready to provide support as required. This option was not available at the standalone MLU at Solihull.

We reviewed the trust’s Prevention of Shoulder Dystocia guideline. This guideline said that staff should discuss mode of delivery including caesarean section with antenatal women who were expecting a baby with an estimated weight of more than 4.5kg for diabetic women and 5kg for non-diabetic women. The guideline was in line with RCOG guidance. During our inspection, we saw elective caesarean sections were performed for women whose baby’s estimated weight was
Doctors told us they generally offered caesarean section to women based on growth centiles rather than weight, which was not in line with the trust guideline. Midwives we spoke with confirmed this was a regular occurrence. Service leads told us doctors might be being more cautious in response to a serious incident earlier in the year. Whilst we were told the guideline might be reviewed, currently staff were not following the guideline and this might mean women were being put at risk by being advised to have surgery that might not necessarily be required.

The service provided an antenatal assessment triage service called PAER. Women could be referred to PAER by community midwives, GPs, A&E or could self-refer. Staff saw women who might be in labour, had pain or were bleeding or felt reduced baby movements. This triage pathway was RAG (red, amber, green) rated and determined how quickly women needed to be seen dependant on their clinical presentation to ensure women and babies were reviewed in a timely way. Women who were in the ‘green’ category should be seen by a midwife within 30 mins and an obstetric review within a maximum of four hours. Amber was to be seen by a midwife within 30 minutes and an obstetric review within 60 minutes. Red was to be seen by a midwife within five minutes and an immediate obstetric review. During the inspection we observed three women were being reviewed. Of these three, only one had been seen by a midwife within 30 minutes, the other two had waited 35 and 45 minutes respectively. We saw women also waited for long periods to be seen by medical staff as there was not always a junior doctor on the rota for PAER. In that event, the on-call team for delivery suite would assess women when available. During our inspection we saw women had waited for five hours for review. Staff we spoke with were not aware of any recent audit of the pathway to assess if the service was meeting these target times.

Band 2 maternity support workers (MSW) supported midwives in PAER, however we saw they were working outside of their competence and performing tasks that were the responsibility of the midwife. We saw MSWs greeting women who attended the PAER, and who then asked women clinical information about their contraction strength and frequency, whether the women thought they were losing amniotic fluid and about their baby’s movements. MSWs told us they would also ask women about any blood loss and would observe blood loss on a pad or in the toilet before referring to a midwife. MSWs would also redirect women to the delivery suite or the Willow MLU if clinically indicated from the history without ever referring to a midwife. We escalated these concerns to the Head of Midwifery, who confirmed MSWs should only be taking demographic information and gave assurances about future practice.

The day assessment unit (DAU) took referrals for women with ruptured membranes before 36 weeks gestation, raised blood pressure assessment and monitoring of small for gestational age babies and general assessment of baby or mother’s well-being. Any additional ultrasound scans could be undertaken within the DAU.

Staff used both electronic and paper based methods for recording the handover of a woman’s care. They used the Situation, Background, Assessment and Recommendation (SBAR) forms for handover when women were moved from any of the wards, delivery suite and PAER and after a shift change. SBAR is a technique that can be used to facilitate and prompt appropriate communication especially amongst healthcare professionals. SBAR stickers were used in the paper records or recorded in the electronic version, and in both versions, both staff members were required to sign or acknowledge the handover.

Obstetric theatres used a modified version of the World Health Organisation (WHO) ‘Five Steps to Safer Surgery’ safety checklist prior to and during each procedure. This is a process recommended by the National Patient Safety Agency (NPSA) for every woman undergoing a surgical procedure. The process involves several safety checks before, during and after surgery to
avoid errors. For each woman’s procedure, the checklists were followed and completed in full. We observed the theatre team completing the Five Steps to Safer Surgery throughout the sign in before induction of anaesthesia, to the sign-out as the woman left theatre. All stages of the WHO safety checklist were completed correctly and were recorded on an electronic record. In the event of an emergency procedure, staff told us sufficient checks would be carried out to proceed without compromising the safety of the woman or baby by delaying the start of the procedure.

Audit data provided by the trust following the inspection, for the three-month period August to October 2018, showed 99.7% compliance with the WHO checklist within the Delivery Suite emergency theatres at Heartlands Hospital.

There was a dedicated fridge to store blood products located within the obstetric theatre area on the Delivery Suite. There was usually four units of blood stored in this fridge in case of an obstetric emergency. However, during our inspection, we saw there was a fault with this fridge, which had been highlighted and was being resolved and alternative arrangements had been made to keep women safe. There was also a blood gas analyser on the delivery suite, in line with national recommendations. This meant staff could quickly analyse blood products from both women and babies to assist with planning care.

Midwifery staff used a paper based early warning assessment tool known as the modified obstetric early warning score (MEWS) to assess the health and wellbeing of all inpatients. This paper based assessment tool enabled staff to identify and respond to a woman whose health was deteriorating and summon additional medical support if required. The MEWS chart included a prompt to staff to consider sepsis when a woman looked sick or had unexpectedly deteriorated and signposted them to the sepsis screening pathway. We reviewed 10 clinical records which included MEWS and saw staff were completing them fully and accurately calculating the scores, and were escalating appropriately when the tool indicated a concern about a woman’s wellbeing.

Baby’s observations were documented on a new-born early warning score track and trigger chart (NEWS). Pulse oximetry was performed on all new-born babies (to measure the oxygen levels) which helped identify babies whose heart and lungs were less healthy.

Anaesthetists ran an antenatal clinic for higher risk women to assess potential anaesthetic complications. This included women with a body mass index (BMI) of more than 40, and those with back or airway problems and those with a complex medical history. Women who were Jehovah Witnesses were invited to attend an appointment at the clinic to discuss the risks associated with refusal of blood products in an emergency.

Women booked for elective caesarean section were seen in antenatal clinic for a pre-operative assessment, where the woman was consented and all blood tests and screening were performed.

**Nurse and midwifery staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Staffing levels were planned and reviewed to ensure women and babies received safe care and treatment. In 2016, the maternity department used the National BirthRate Plus acuity tool to calculate midwifery staffing levels, in line with guidance from the National institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a patient). The current ratio of midwives at Heartlands Hospital was one to 27 women.
Staffing levels were displayed on each of the ward areas and delivery suite and during the inspection we saw expected staff levels were mostly in line with actual staffing numbers. Staff worked a mixture of shifts including earlies, lates, long days and nights and the planned number of qualified staff for Delivery Suite for each shift was 15 midwives. The trust provided data for staffing levels for the period 24 September to 21 October 2018. Staffing levels were mostly met for early shifts, however there were seven late shifts and nine nights shifts where the planned staffing levels were met. There were three occasions when there were 11 midwives on the shift. At the time of our inspection, we were told there were 18 midwives on maternity leave trust wide, which influenced staffing levels.

Staff we spoke with told us the staffing was generally well managed, however some midwives were concerned about the staffing on the postnatal wards, particularly at times of peak activity on the delivery suite. All of the elective sections were now being carried out at the Heartlands site, which meant an increased workload for the postnatal wards, with no additional staffing allocation.

We were told there was always two experienced band 7 midwives on every shift, one acted as the delivery suite coordinator who was usually supernumerary and the other provided cover for breaks, support for staff and was the unit bleep holder. During our inspection we saw there were two band 7 staff on each shift. Student midwives we spoke with told us they were always supernumerary.

There was a team of 14 midwives working on the Willow midwifery led unit (MLU) of which five were core staff and the rest were rotational. Two midwives were rostered for each shift. We saw specialist bereavement midwives had their own staffing rota to ensure there was always one of the team available to support staff and women.

Core staff on the midwife led unit at Solihull were not called to help at the consultant led unit at Heartlands as part of the staffing escalation, however, community midwives were occasionally called. Community midwives also covered the Solihull MLU staffing escalation, which they told us was frustrating when there were so few births and was not a good use of their time. Community midwives we spoke with felt pressured at times when they were called out of hours, due to their workload the following day.

### Planned vs actual

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing and midwifery staff in maternity.

The overall fill rate for qualified nursing staff dropped was around 95% for both time periods.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>235.3</td>
<td>246.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 2.7% for nursing staff in maternity. This was lower than the trust target of 5% for nursing staff.
The breakdown by site was as follows:

- Birmingham Heartlands Hospital: 2.4%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 12.5% in maternity for qualified nursing and midwifery staff. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:
- Birmingham Heartlands Hospital: 11.5%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 and March 2018, the trust reported a sickness rate of 5.1% in maternity for qualified nursing and midwifery staff. This is above the trust target of 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:
- Birmingham Heartlands Hospital: 5.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

**Birmingham Heartlands, Good Hope and Solihull Hospitals**

From April 2017 to March 2018 the trust reported that for qualified and unqualified nursing staff 1.0% of actual hours were filled by agency staff and 12.1% by bank staff across Birmingham Heartlands, Good Hope and Solihull hospitals. The number of unfilled hours, a breakdown by site and staffing type was not provided.

(Source: Nursing bank agency - HGS PIR Return)

Service leads at the Heartlands Hospital Maternity Unit told us the trust operated a ‘bank’ of staff and used some agency staff if shifts could not be filled by bank staff or staff working extra shifts.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

**Medical staffing**

Access to medical support was available seven days a week. Consultant obstetricians operated a system of consultant ‘hot week’ on a rota, which meant consultants were resident and on call for the delivery suite. Consultant obstetricians were resident on the delivery suite from 8am to 11pm seven days a week. This was in line with the safer childbirth/Royal College of Obstetricians and Gynaecologists (RCOG) recommendations for the minimum number of hours of consultant presence on the labour ward per week. Consultant anaesthetists covered delivery suite from 8.00am to 8.30pm Monday to Friday and from 8.00am to 12.30pm on weekends. Outside of these hours the consultant obstetricians and anaesthetists worked a non-resident on-call system to
support the speciality registrars and were available to attend the maternity unit within 30 minutes when requested.

We attended an evening handover which was multi-disciplinary and saw the on-call consultant obstetricians and anaesthetists were present, together with more junior doctors and midwife co-ordinators.

An anaesthetist was available immediately always for the maternity unit and was free from other duties.

Service leads told us most of the junior doctor's rota was filled. Staff told us and we saw there was not always a dedicated doctor for the PAER, which meant women could wait for long periods to be reviewed by the on-call team but did not impact on safety. Midwifery staff on the wards told us it was sometime difficult to get a doctor to review women as delivery suite always took priority. Junior doctors we spoke with told us they were generally happy with the rota, and were still able to access teaching sessions.

**Planned vs actual**
The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in maternity.

The overall fill rate for medical staff remained similar at 95.7% in March 2018 and 96.0% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>37.3</td>
<td>38.8</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 2.7% for medical staff in maternity. This was lower than the trust target of 10% for non-nursing staff.

The breakdown by site was as follows:

- Birmingham Heartlands Hospital: 2.1%

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From April 2017 and March 2018, the trust reported a turnover rate of 5.9% in maternity for medical staff. The trust only supplied data which pertained to Birmingham Heartlands Hospital.

*(Source: Routine Provider Information Request (RPIR) - Turnover tab)*

**Sickness rates**

From April 2017 and March 2018, the trust reported a sickness rate of 1.1% in maternity for medical staff. This is below the trust target of 4.0% for Birmingham Heartlands Hospital and Good
Hope Hospital.

The breakdown by site was as follows:
- Birmingham Heartlands Hospital: 1.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From April 2017 to March 2018 the trust reported that 251 shifts were filled by locum medical staff, 1,048 by bank medical staff and that 89 were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>134</td>
<td>589</td>
<td>42</td>
<td>723</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

In May 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the 99.1 whole time equivalent staff working in maternity at University Hospitals Birmingham NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>36%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Incidents

The service managed patient safety incidents well. Staff recognised incidents 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 women honest information and suitable support.

Never Events

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

University Hospitals Birmingham NHS Foundation Trust

From April to July 2018, the trust reported no incidents classified as a never event for maternity services.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018, the trust reported no incidents classified as a never event for maternity services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

University Hospitals Birmingham NHS Foundation Trust

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in maternity which met the reporting criteria set by NHS England from April to July 2018.

This occurred at Birmingham Heartlands Hospital in June 2018 and related to a maternity / obstetric incident: baby only (this include foetus, neonate and infant).

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2017 to March 2018.

The breakdown by type of incident reported were:

- Maternity/Obstetric incident: baby only (this include foetus, neonate and infant) with three incidents (75% of total incidents)
- Maternity/Obstetric incident: mother and baby (this include foetus, neonate and infant) with one incident (25% of total incidents)

Site specific information can be found below:

- Birmingham Heartlands Hospital: three incidents

(Source: Strategic Executive Information System (STEIS))
Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them where appropriate. Staff reported incident through the trust’s electronic incident reporting system. Staff working within the governance and risk teams used the electronic system to provide feedback given in response to staff reports, and recorded all the evidence relating to the incident.

Service leads told us they received approximately 250 incident reports per month. At the time of our inspection there were around 30 incidents that were open and overdue. We were told this was incidents classified as low or no harm and might be due to a review external to the division. No higher risk incidents were overdue. We reviewed minutes of the Obstetrics and Gynaecology Quality and Safety Group meeting from October 2018 and saw the group had sight of the serious incident action log. One action from this meeting was for the clinical service lead to review the serious incident action log to ensure necessary actions were completed and closed.

We reviewed the quality governance report for obstetrics from quarter two (July to September) 2018/19. We saw there were 2312 obstetric incidents reported for the whole service from July 2017 to September 2018. Of these 1735 (75%) were no harm, 537 (23%) were low harm, 35 (1.5%) were moderate harm, four (0.01%) were severe harm and one was catastrophic. The top two sub categories were post-partum haemorrhage for greater than 1000mls and unexpected admission to the Neonatal unit for term babies.

Incidents were being graded according to risk and harm, however we were not assured that the grading of some incidents was appropriate. For example, we saw incidents where women had significant bleeding following the birth which is not expected and requires further management and treatment which had been graded as no harm. Other incidents included women who had experienced serious perineal trauma because of childbirth and babies born after 37 weeks gestation who had an unexpected admission to the Neonatal Unit for enhanced care and treatment which was also graded as no harm. We raised this with the trust at the time of our inspection. Service leads explained they considered the grading of all incidents but any incidents where there was no “avoidable” harm were likely to be downgraded to low or no harm. We could not be assured that incidents were graded appropriately according to harm.

We saw root cause analysis investigations had taken place in relation to serious incidents. (Root cause analysis is an approach for identifying the underlying causes of why an incident occurred). We reviewed the serious investigation reports for four maternity incidents across the service and saw there had been a full investigation with input from the multi-disciplinary. Learning from the incident had been recorded along with agreed actions, for example reviewing guidelines or changes to practice and escalating concerns to senior medical staff.

Staff understood their responsibilities about the Duty of Candour (DOC) regulation and were aware of the trigger for the application of duty of candour, which was for moderate harm and above. DOC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Staff could give examples of where they had been open and honest with women even when not required to do so by the DOC regulation, for example following a medicines error and we heard medical staff confirming DOC had been carried out in relation to an incident on the delivery suite. We saw DOC had been carried out in our review of the four RCAs.

**Safety Thermometer**

The service used safety monitoring results well. Staff collected safety information and
shared it with staff, women and visitors. Managers used this to improve the service.

Maternity services took part in both the classic and the maternity national safety thermometer scheme. The Classic Safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, urinary tract infections (in patients with a catheter) and blood clots. Data for this was collected on an identified day each month to indicate performance in key safety issues.

The Maternity Safety Thermometer is a national system that was designed to support improvements in women’s care and experience. The maternity thermometer also records data on one day a month, the proportion of mothers who have experienced harm free care. It records harm associated with maternity, such as perineal trauma, abdominal trauma, postpartum haemorrhage, infection and women’s psychological perception of safety.

We saw safety thermometer data displayed within the unit however it was not prominently displayed and some was out of date, for example in antenatal clinic the information was dated August 2017.

The service maintained a trust wide maternity quality dashboard. This dashboard was called the HGS (Heartlands, Good Hope and Solihull) Obstetric Indicators 2018-19 included the safety thermometer metrics, apart from women’s psychological perception of safety. These were monitored for the whole month as opposed to one day a month. These metrics were monitored by the clinical governance structure monthly.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness, however not all guidelines had been recently reviewed. Managers checked to make sure staff followed guidance.

Local policies and guidelines were written in line with evidence based standards and guidance from professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). Midwives and medical staff we spoke to were able to describe how their practice was informed by up to date evidence and guidance.

At the time of our inspection there was 105 guidelines relating to maternity and 29 (28%) of those had passed the date for review. Service leads told us this was an improving picture. The service was working with other providers in the local maternity system, the Birmingham and Solihull United Maternity and New-born Pathway (BUMP) to produce joint guidelines, which we were told made the process slower. The guideline midwife’s post had been vacant from December 2016 until November 201. The post had been funded for 18 hours per week by BUMP from November 2017, but the trust had not directly funded any hours. During the period there had been no guideline midwife, there had been a lead consultant obstetrician for guidelines, however guidelines were not prioritised and many passed their renewal date. Since the new appointment at least 27 guidelines had been renewed. Service leads told us the expectation was for all guidelines to be in date by January 2019. However, this meant that we did not have assurance that all guidelines were in line
with any new evidence or recommendations and, currently, women might not be getting the safest and most effective care and treatment.

The trust had fully implemented the NHS England’s Saving Babies Lives; A care bundle for reducing stillbirth. Elements of the care bundle included reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movements and effective fetal monitoring in labour.

We saw mandatory training incorporated issues that were raised through clinical governance or promoting latest best practice, for example including the use of bladder filling during a post-partum haemorrhage and promotion of aspirin in the antenatal period for women at risk of pre-eclampsia.

We reviewed the clinical audit programme provided by the trust following the inspection. Topics for audit included consent and documentation, elective caesarean section, perineal trauma, induction of labour, shoulder dystocia, sepsis, intrapartum fetal monitoring, massive obstetric haemorrhage, small for gestational age babies, reduced fetal movements and antenatal screening. Staff told us monthly meetings were held to track progress and learning.

Antenatal key performance indicators (KPI) monitored performance against nine NICE maternity standards. Performance was monitored for seven of the standards against either acceptable (green) or achievable standards (amber). Trust wide data provided following the inspection showed the service exceeded the achievable standard in one of the KPIs (ID2 – timely assessment of women with hepatitis B), had acceptable performance in five of the KPIs, but did not meet the standard (red) for one of the KPIs (NP2 – Newborn and Infant physical examination (NIPE) timely assessment of developmental dysplasia of the hip. The trust’s performance was 75% against the acceptable level for this standard of 95%.

The service did not offer enhanced recovery programme for women undergoing elective caesarean section. Enhanced recovery is an evidence-based approach designed to help people recover more quickly from surgery, including caesarean section. Service leads told us this was being considered.

The trust policy for disposal of fetal remains was in line with Human Tissue Authority guidance (2015). Staff released miscarried remains to families from the Eden bereavement suite on a regular basis. Although women may have miscarried at other locations within the hospital, this ensured the process was carried out with care and dignity. There was a database to track and update the process of the release from the mortuary or histology to reduce delays and keep families informed. The service released approximately 50 remains in this way in 2017.

We reviewed five cardiotocograph (CTG) traces across the two obstetric sites, Heartlands Hospital and Good Hope Hospital. Documentation standards were mostly consistent and in line with the trust’s interim fetal monitoring guideline. Staff carried out hourly ‘fresh eyes’ on the CTG traces. ‘Fresh eyes’ is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications from being missed. The process is recommended by NHS England’s Saving Babies Lives; A care bundle for reducing stillbirth.

**Nutrition and hydration**

Staff gave women enough food and drink to meet their needs and improve their health.

As part of the acquired Heart of England NHS Foundation Trust, the maternity service had achieved full accreditation in the UNICEF Baby Friendly initiative accreditation programme in July 2013 and was re-accredited in July 2016. The service was due for re-assessment in January 2019.
The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding and raise standards of care for all babies. The UNICEF UK Baby Friendly Accreditation has four levels which starts with a certificate of commitment. Stage one assessment is building a firm foundation, stage two is an educated workforce and stage three is full accreditation. We saw posters displayed within the unit to promote breastfeeding. Data obtained during the inspection showed the current breast-feeding initiation rate was 71%, which is about the same as the national average (74%).

Staff monitored the expressed breast milk stored in the milk fridge. During our inspection there was milk in the fridge, which we saw to be labelled adequately and dated. Staff told us that it could remain in the fridge for up to 24 hours and then would be disposed of appropriately. The fridge was unlocked, and it was not kept within a locked room which could pose a risk of the milk being tampered with or being given to the wrong baby.

Intrapartum care plans included an assessment of hydration and nutrition and staff told us women were encouraged to eat and drink normally in labour if it was safe to do so.

A vending machine with assorted snack was available in the foyer of the maternity unit. Women had access to snacks between meals and we saw tea, coffee, water and fresh fruit was available on the wards.

**Pain relief**

*Staff assessed and monitored women regularly to see if they were in pain. They gave additional pain relief to ease pain.*

Women could access pain relief during birth and post operatively in a timely manner.

There was a birthing pool on the delivery suite that women could use to ease their pain in labour. Nitrous oxide (a pain relieving gas) was piped in all birthing rooms on the delivery suite. Stronger painkiller by injection was available for women who required stronger pain relief.

Epidurals (an injection of anaesthetic into the spinal area) were available for women on the delivery suite 24 hours per day, seven days per week. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance states the average waiting time for women requesting an epidural to receiving one should be within 30 minutes. An anaesthetist we spoke with told us women generally received epidurals within 30 minutes however we were told there was no routine audit of this service.

An assessment of pain was included and scored on the MEWS chart and we saw staff escalated to anaesthetists if they were caring for women and could not control their pain, for example post caesarean section.

Women we spoke with were happy with the options they had been given for pain relief and did not report a long waiting time for any pain relief.

**Patient outcomes**

*Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them, however the data used was not always robust.*

The service maintained a maternity quality dashboard, called the HGS (Heartlands, Good Hope and Solihull) Obstetric Indicators, which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. In addition, the service was working with other providers in the local maternity system, the Birmingham and
Solihull United Maternity and New-born Pathway (BUMP) to create a joint local maternity system (LMS) dashboard. During our visit to the Good Hope Hospital, we saw the dashboard data was split by site. Following the inspection, we requested a copy of the dashboards, split by site, however the trust provided the HGS and the LMS dashboards for the service as whole. We reviewed both dashboards and saw there was discrepancies in the data, for example the total number of deliveries (mothers delivered) displayed on the HGS dashboard was 4753, compared to 4763 on the LMS dashboard. Other discrepancies were noted for example the average induction of labour rate displayed on the HGS dashboard was 33.64%, compared to 34.23% on the LMS dashboard. There was discrepancy with the data displayed on the dashboard relating to caesarean section as the total numbers of procedures carried out did not add up to 100%.

We are not assured, therefore, about the robustness of the data or the oversight of the dashboards. We have used the HGS dashboard data to report outcomes.

The dashboard presented data relating to activity, workforce, antenatal, intrapartum, perinatal, quality indicators and risk. This included data on the number of deliveries, broken down into mode of delivery, trauma at delivery (postpartum haemorrhage; excessive blood loss or perineal trauma 3rd and 4th degree) and neonatal unexpected admission to the neonatal unit. The dashboard captured the number of women who had an induction of labour, and the number of antenatal bookings performed before 10 weeks gestation were also captured. Staff told us an audit for induction of labour had just been completed, although the findings had yet to be analysed. Data was captured relating to the reasons for the induction, the time of admission to the start of the process and the time women waited to have an artificial rupture of membranes if applicable.

We reviewed minutes of the Obstetrics and Gynaecology Quality and Safety meeting from October 2018 and saw the maternity dashboard, parameters for outcomes and trends and themes was included in the discussions.

Staff told us the service was part of the first wave of NHS Improvement Maternal and Neonatal Health Safety Collaborative and were using quality improvement methodology. One of the workstreams was around improving compliance with time from decision to surgery for emergency caesarean section, which should be undertaken in less than 30 minutes. Trust-wide, prior to the workstreams the service achieved 72% compliance, which had improved to over 90% compliance. There was another workstream to improve the number of term babies admitted unexpectedly to the neonatal unit. Staff had worked on producing a care bundle and had changed practice for example the administration of buchul (via the mouth) glucose for babies had improved blood sugars,

The service submitted data to the National Maternal and Perinatal Audit (NMPA) as part of the acquired Heart of England NHS Foundation Trust and no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement. The audit captures site-specific results for key measures of maternity care. These included instrumental delivery, episiotomy rates (a cut to aid delivery of the baby), induction of labour, early elective caesarean section, babies who were small for gestational age at 40 weeks, low Apgar scores (a guide for staff as to whether the baby needs additional resuscitation at birth) and 3rd and 4th degree tears. Data was submitted for the 11 metrics and indicated the service was performing in line with or better than the expected range for a site of this size apart from episiotomy rates, which were 29.3% of all deliveries, which was higher (worse) than the national average of 22.7%. Managers we spoke with were not sighted on the raised episiotomy rates as they had not been discussed at clinical governance or labour ward forum. However, managers told us they did not feel episiotomy rates were outside of normal range and told us they had purchased specialised scissors to aid technique and staff confidence.
The Willow MLU averaged approximately 50 births per month and the current rate of transfer from the MLU to the obstetric unit was 13.5%.

National Neonatal Audit Programme

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital

In the 2017 National Neonatal Audit Birmingham Heartlands Hospitals performance in the two measures relevant to maternity services was as follows:

• Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

Of the 194 eligible cases identified for inclusion, 83.4% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital did not meet the audit’s recommended standard of 85% for this measure.

• Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

Of the 69 eligible cases identified for inclusion, 15.9% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was lower than the national aggregate of 43.5%, and put the hospital in the bottom 25% of all units.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Maternity active outlier alerts

University Hospitals Birmingham NHS Foundation Trust

As of September 2018, there were no active maternity outliers at the trust.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

As of September 2018, the trust had one active maternity outlier. This related to elective caesarean sections and was generated by CQC in October 2017. The alert is currently being followed up by the inspection team.

All elective caesarean sections (CS) from across the service were carried out at Heartlands Hospital. Very few elective CS were carried out at Good Hope Hospital. Data provided by the trust
demonstrated the service was monitoring the caesarean section rate through the HGS (Heartlands, Good Hope and Solihull) Obstetric Indicators 2018/19 (dashboard) and as part of Birmingham and Solihull United Maternity and New-born Pathway (BUMP). The service used the Robson group classifications to differentiate between the different categories of women which gave service leads a better understanding of the CS rate.

We reviewed the HGS obstetric indicators dashboard and saw for the six months up to and including September 2018. The average proportion of elective CS was 11.92%, which was lower (better than) the England average (12.1%) but higher (worse) than the trust target (of less than 10%). The proportion of emergency CS was 18.37%, which was higher (worse) than the England average (15.4%) and the trust target (of less than 17%). The overall CS rate was 33.45% was higher (worse) than the England average (27.5%) and the trust target (less than 27%).

Staff had introduced vaginal birth after caesarean (VBAC) clinics to discuss mode of birth options with women who had previously had a CS. From April to September 2018, the average VBAC rate was 19.98% which was worse than the trust’s target of 25%. Staff were offering external cephalic version (ECV) to women who had an identified breech (where the baby was presenting bottom first) baby. ECV is a method of turning the baby prior to the start of labour which is the optimum presentation to achieve a normal birth).

Standardised Caesarean section rates and modes of delivery

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>2,898</td>
<td>31.0%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>905</td>
<td>9.7%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>5,543</td>
<td>59.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>9,346</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.  
¹Includes elective and emergency caesareans  
²Includes forceps and ventouse (vacuum) deliveries  
³Includes breech and normal (non-assisted) deliveries  

Data includes both University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust.

Standardised caesarean section rate (April 2017 to March 2018)

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesarean rate</td>
</tr>
<tr>
<td></td>
<td>(n)</td>
<td>(n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>1,357</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>1,541</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>2,898</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
Delivery methods are derived from the primary procedure code within a delivery episode.
Data includes both University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

University Hospitals Birmingham NHS Foundation Trust

The trust did not take part in the 2017 MBRRACE audit, as this audit was compiled prior to the acquisition, when University Hospitals of Birmingham was not providing maternity services.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 7.15. This was more than 10% higher than the average for the comparator group of 6.2, placing it in the red band.

Service leads told us the MBRRACE data indicated they were not an outlier in comparison with other maternity services in the local area. The published Public Health Outcomes Framework (August 2017) illustrated the areas where Birmingham performed badly and these included infant mortality and the low birth weight of term babies which was 50% higher than the England average. Service leads told us thestill birth rates had improved in 2017 and they were working with other providers in the local maternity system, the Birmingham and Solihull United Maternity and Newborn Pathway (BUMP) to further reduce stillbirth, neonatal deaths and extended perinatal mortality rates. Data provided by the trust following the inspection showed from April to September 2018, the average still birth rate across the service as a whole was 0.5%, which was lower (better) than the trust target of 3.9%.

(Source: MBRRACE UK)

Competent staff

The service made sure staff were mostly competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
The service had processes in place to identify training needs and compliance, and address any issues identified. We reviewed the trust's Professional Midwifery Service standard operating procedure (SOP) which outlined the structure of the support that would be provided to midwives. The SOP gave clear roles and responsibilities for practice development midwives, professional midwifery advocates and the preceptorship midwife.

The role of the supervisor of midwives (SoM) was discontinued on 1 April 2017 following changes to legislation. The trust implemented the new A-EQUIP (advocating education and quality improvement) model of midwifery supervision, with professional midwifery advocates (PMAs). The service employed two whole time equivalent (WTE) PMAs to provide support to midwives across the maternity service, one full time at Good Hope Hospital and two-part time staff at Heartlands hospital. However, community midwives we spoke with were not aware this new model had been implemented.

Practice development midwives (PDM) had undertaken a training needs analysis (TNA) which was based on the Delivery Suite strategy to ensure staff were confident and competent to undertake their role. PDMs told us and we observed they had made innovations to the training programme to make the sessions more interactive and engaging for staff, using games and different learning styles and mediums. Staff told us they found the sessions very enjoyable and helped them remember what they had been taught. The training was to be evaluated to assess how effective it was.

Staff attended annual multi-disciplinary training sessions. Midwives were required to attend three mandatory emergency skills and study days. We saw the training included sessions covering emergency care for both mothers and babies. Topics covered included major obstetric emergencies including neonatal resuscitation, haemorrhage and maternal collapse, shoulder dystocia (where a baby’s shoulders get stuck during a vaginal delivery), breech birth, cord prolapse, pre-eclampsia (a serious complication of pregnancy), sepsis and fetal wellbeing and CTG interpretation. All staff, including medical staff, were required to pass an assessment for CTG interpretation and we were told there was a procedure in place to support staff who did not reach the 75% pass rate.

Staff told us ‘live’ emergency drill training was held on the wards approximately every six months. They told us the PDM kept a record of all drills and circulated a debrief document to all staff to share learning.

Some midwives had completed the acute illness management (AIMs) course which covered the identification and escalation of a deteriorating woman, to care for women in the high dependency beds. The in-house training programme commenced in June 2017 and was included on the service’s TNA. It was planned for all midwives to be trained and recertified on a four-year rolling programme. The training was initially targeted at band 6 and 7 midwives and, data provided by the trust demonstrated that 65 midwives (27%) had completed the course. Trainers were senior midwives with either a teaching qualification or had undertaken a “train the trainer” course.

There was a dedicated theatre team including operating department practitioner (ODP) and ‘scrub’ nurses who were managed by main theatres. Midwives acted as ‘scrub’ nurses in the obstetric emergency theatres on very rare occasions, when the second theatre was required for an emergency and no other team was available from main theatres. We were told midwives completed training and undertook regular refresher training to maintain their competency.

The service had received a grant from the Health Education England Training Fund, which had been spent on external CTG masterclass sessions for all consultant obstetricians and band 7 labour ward co-ordinators, to improve decision making around fetal wellbeing and support for staff caring
for women being monitored. Staff had also received Human Factors training. (Human factors training encourages staff to think about how people might behave in certain situations, particularly when under stress, and how they can use that knowledge to improve safety.)

Midwives on the postnatal wards and Willow MLU had completed training in performing the newborn and infant physical examination (NIPE) checks. Staff were allocated to NIPE checks on the staffing rota. The aim was for all the MLU core midwives to be able to perform these checks. This meant the discharge process for women and babies would be quicker and would be more continuity of care.

**Appraisal rates**

From April 2017 to March 2018, 86.1% of staff within maternity care at the trust received an appraisal. This is above the trust target of 85% for Birmingham Heartlands, Good Hope and Solihull Hospitals.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>31</td>
<td>31</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>382</td>
<td>439</td>
<td>87.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>60</td>
<td>69</td>
<td>87.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>72</td>
<td>90</td>
<td>80.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>14</td>
<td>21</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

**Birmingham Heartlands Hospital**

From April 2017 to March 2018, 86.0% of staff within maternity care at Birmingham Heartlands Hospital received an appraisal. This is above the trust target of 85% for Birmingham Heartlands, Good Hope and Solihull Hospitals.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>248</td>
<td>284</td>
<td>87.3%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>69</td>
<td>83</td>
<td>83.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>7</td>
<td>14</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit women. Doctors, nurses and other healthcare professionals supported each other to provide good care.

All necessary staff, including those in different teams, services and organisations were involved in assessing planning and delivering care and treatment. For example, neonatal teams worked with obstetricians and fetal medicine specialists during the antenatal period to produce care plans for babies.

Staff within antenatal and newborn screening and fetal medicine told us of close working relationships with other providers in the local area, to plan care and support women whose babies had been identified as having serious conditions or deformities, which could not be managed
solely within the trust. Staff told us there was a high incidence of neural tube defects and anencephaly (a disorder of the brain and head) for babies within the trust. For women who chose to terminate their pregnancies, staff worked closely with bereavement midwives to provide support and care.

The twice daily multidisciplinary handover meeting involved obstetric, anaesthetics and midwifery staff sharing information and planning care. The handover included discussions regarding women throughout the unit including those in the Pregnancy Assessment Emergency Room (PAER).

Staff working in the operating theatres worked in a collaborative way to provide good care for women having planned caesarean section. We saw there was good communication and teamwork.

Neonatal nurses and nursery nurses worked with midwives on the postnatal wards to care for transitional care babies. (Transitional care refers to babies who require more specialised neonatal care, such as phototherapy treatment for jaundice or intravenous antibiotics but do not need to be on the neonatal unit). However, there had recently been a change to the arrangements on one of the postnatal wards which meant midwifery staff were taking on additional tasks from the neonatal nurses, for example checking of intravenous antibiotics for babies and some staff told us they did not feel confident undertaking the tasks they were now being asked to complete. Nursery nurses told us they were being asked to assist with certain aspects of feeding they had not been trained to provide, for example on the side feeding. Service leads told us adequate training had been given and suggested staff had not yet become accustomed to this new model of care.

**Seven-day services**

The PAER was available 24 hours a day. The day assessment unit (DAU) was open every day from 8.30am to 8.00pm.

Community midwives made home visits and held antenatal and postnatal visits seven days a week and were available 24 hours per day, seven days per week to facilitate home births.

Consultant obstetricians and anaesthetists were either resident on the unit or on-call 24 hours per day, seven days per week. In addition, delivery suite had access to middle grade obstetric staff 24 hours a day.

The obstetric theatres were always available for emergency procedures and there was a dedicated middle grade anaesthetist for the maternity unit.

**Health promotion**

Initial booking risk assessments and ongoing screening monitored and identified abnormalities or risk factors for example raised body mass index, low blood haemoglobin levels and smoking. These were then discussed and care planned with all relevant parties, including women and partners.

Staff working within the service actively encouraged women to stop smoking. Carbon monoxide testing was offered to all women at booking, regardless of their smoking status.

Healthy eating and weight management advice was also provided as part of diabetic care for women both before and during pregnancy. Specialist midwives held clinics for diabetic women and provided training for midwives to care for and support women with diabetes.

Influenza and whooping cough vaccines were offered to all pregnant women after 20 weeks gestation, by community midwives.
**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Medical staff informed women about the risks and benefits of obstetric procedures, such as emergency caesarean sections or instrumental deliveries. Written consent was obtained from women prior to surgery and checked by theatre staff prior to commencing procedures. Staff asked for verbal consent from women prior to any procedures or care.

We saw staff documented when consent for procedures had been gained.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust combines safeguarding level 2, mental capacity and deprivation of liberty (DoLS) training.

**Birmingham Heartlands Hospital**

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for qualified staff in maternity at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for this training module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in maternity at Birmingham Heartlands Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>13</td>
<td>18</td>
<td>72.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this training module.
Is the service caring?

Compassionate care

Staff mostly cared for women with compassion. Women and relatives confirmed that staff treated them well and with kindness.

Staff understood and respected the personal, cultural, social and religious needs of women and those important to them. Women and their relatives we spoke without exception with told us they were treated with dignity, kindness and respect.

We observed interactions, both face to face and on the telephone, between members of staff including midwives, receptionists and health care assistants and women, their relatives and visitors. We saw staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. However, we observed several occasions when staff used inappropriate language to describe women to other colleagues. For example, we saw a woman being transferred to the postnatal ward from theatres and overheard one midwife asking another “Where is this section going?” in earshot of the woman herself. Another occasion we observed a midwife on delivery suite shouting down the corridor to “move induction one” to another room.

Staff made sure that women’s privacy and dignity needs were understood and respected. We observed staff knocking and asking for permission to enter before going into women’s rooms. Staff drew curtains around women being assessed and cared for in both the pregnancy day unit and the triage unit to maintain their privacy. We observed staff protected women’s dignity by covering them as much as possible in the theatre environment.

Friends and family (FFT) data showed an improvement in the number of women who use the service and those who are close to them who responded positively about the way staff treated people. Bereaved families are not included in the FFT. The service devised a bereavement feedback form with input from a national charity, which is sent to families routinely two weeks after their discharge. Data collected by the service for 2017 showed 100% of the feedback included complimentary comments about the service, with 97% of respondents scoring the service eight out of ten or above.

Friends and Family test performance

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Friends and family test performance (antenatal), University Hospitals Birmingham NHS Foundation Trust
The trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was suppressed due to low figures in April and May 2018. In June 2018 the trust’s performance was lower than the England average.

**Friends and family test performance (birth), University Hospitals Birmingham NHS Foundation Trust**

From April to June 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was consistently worse than the England average.

**Friends and family test performance (postnatal ward), University Hospitals Birmingham NHS Foundation Trust**
From April to June 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

**Friends and family test performance (antenatal), Heart of England NHS Foundation Trust**

From July 2017 to March 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was consistently worse than the England average.

*Please note* – no data is available for November 2017 from NHS England for any trust due to data quality issues.

**Friends and family test performance (birth), Heart of England NHS Foundation Trust**
From July 2017 to March 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was consistently worse than the England average.

Please note – no data is available for November 2017 from NHS England for any trust due to data quality issues.

Friends and family test performance (postnatal ward), Heart of England NHS Foundation Trust

From July 2017 to March 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2017
University Hospitals Birmingham NHS Foundation Trust

The trust did not participate in this survey as this was prior to acquisition, at a time when University Hospitals Birmingham NHS foundation Trust did not have maternity services.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust performed similar to other trusts for 15 out of 16 questions in the CQC maternity survey 2017 and worse for one question ‘During your labour, were you able to move around and choose the position that made you most comfortable?’

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.71</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.22</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.60</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.21</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.09</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.95</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.48</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.35</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>8.74</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.43</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.58</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.96</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.29</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.73</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.48</td>
<td>About the same</td>
</tr>
</tbody>
</table>
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

8.52 About the same

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

**Emotional support**

Staff provided emotional support to women to minimise their distress.

Staff provided compassionate care for women and relatives who had suffered a bereavement. A team of specialist bereavement midwives directly supported women and provided support and guidance to staff to enable them to meet family’s needs. Bereavement midwives worked a rota and carried a bleep so they were accessible always provide advice and support to other staff caring for women. The service provided spiritual care and religious support for women and relatives as needed. For example, women could be referred to the chaplaincy service for support 24 hours a day, seven days a week. Multi-faith and no-faith options were also available.

Staff demonstrated an understanding of the distressed caused by baby loss within a family. To raise the awareness and encourage people to talk about grief and loss, during Baby loss awareness week, staff held an event in the main entrance of the hospital. They also held services for families who have suffered the loss of a baby and have been cared for at the hospital. Staff told us they made extra efforts to minimise women’s distress, for example, when staff knew women were leaving the building with their deceased baby, they made arrangements with the lift engineers to hold the building lifts so there was no delay and the family did not have to share the lift with anyone else.

Staff regularly assessed women’s mental health, both in the antenatal and postnatal period, using recognised assessment tools in line with National Institute for Health and Care Excellence (NICE) guidance.

Staff told us women’s physical and psychological needs were regularly assessed and addressed whilst in the maternity unit. These assessments included nutrition, hydration, pain, personal hygiene and anxiety. Women we spoke with told us all their needs had been met.

**Understanding and involvement of patients and those close to them**

Staff mostly involved women and those close to them in decisions about their care and treatment.

Staff routinely involved women who used the services and those close to them in planning and making shared decisions about their care and treatment. Most women we spoke with told us they were given sufficient information to make choices about their care.

Birthing partners were included and involved in the care of their partner and new-born baby, however there were no facilities for partners to stay overnight on the postnatal wards. We spoke to three partners who told us they felt involved and included in the decisions about their partner’s care.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

Women could access a range of antenatal and postnatal care. Midwife led clinics were held in GP surgeries. Midwifery-led and consultant-led clinics were mostly held at Heartlands Hospital. In addition, consultant-led antenatal clinics were held at the Solihull Hospital. This meant women living to the south east of the area could access services without having to travel further into central Birmingham. Antenatal triage and a range of additional maternal and fetal assessments were available from the PAER and day assessment unit (DAU).

Women assessed as low risk from across the trust could choose the stand-alone midwifery led unit (MLU) at Solihull or the alongside MLU at the Heartlands Hospital. (Stand-alone means entirely separate to an obstetric unit, whereas alongside means next to or in close proximity to an obstetric unit). The MLU at the Heartlands hospital was called Willow Ward, which had three birthing rooms. Women who were planning to use the MLU were offered an appointment with a midwife on Willow Ward at 34 weeks gestation so they could familiarise themselves with the environment and the staff.

The trust employed two consultant midwives, one for each of the obstetric units but who worked across both sites. The held weekly antenatal clinics to support women with birth choices, acting as advocates for women who wished to birth outside of guidelines.

The trust employed several specialist midwives to provide care for women and support staff to care for women with additional needs. This included specialist midwives for safeguarding, diabetic women, bereavement, women with perinatal mental health concerns, those who experienced substance misuse or domestic abuse, those who were homeless, refugees or asylum seekers, women who were teenagers or who had experienced female genital mutilation.

There was a dedicated elective caesarean section list for the obstetrics, which was carried out in an operating theatre separate from the emergency theatres. This meant women booked for an elective section did not have to wait for staff to complete any emergency procedures before their surgery could proceed.

The neonatal intensive care unit was situated in the same building as maternity unit. Heartlands Neonatal Unit is a level 3 unit comprising of six intensive care unit (ITU) cots; six high dependency care unit (HDU) cots and 20 special care cots, and was the regional cooling centre. This meant the unit could care for babies born at the unit at any gestation, depending on capacity. The service had a dedicated transitional care bay on Aspen Ward. This meant that babies who required more specialised neonatal care, such as phototherapy treatment for jaundice or intravenous antibiotics were cared for on the postnatal wards and were not separated from their mothers unless necessary.

There was a bereavement suite, called the Eden suite, situated on an annex of one of the postnatal wards which was available to women of 12 weeks gestation. The suite comprised two bedrooms and one sitting room. The bedrooms could be used as delivery rooms for women who were experiencing fetal loss without additional complications. Otherwise they were used as postnatal rooms. Women and their families could stay for as long as they wished and staff provided cuddle (cold) cots to ensure babies could stay longer with their parents. Memory boxes, which included photographs and hand and footprints, were made up for parents who suffered a pregnancy loss.
The Eden Suite was accessed through the Aspen Ward. There was also an alternative entrance which meant families could avoid having to walk through the maternity unit. We saw this entrance led to a quiet and peaceful memorial garden which was opened in Summer 2018. Staff told us women and their families could take their deceased baby into the garden for some quiet family time if they wished.

Bereavement midwives supported and trained staff to provide care for families after a pregnancy loss. They supplied clear guidance to staff to ensure all women and families were offered appropriate care and supported to make informed decisions at a difficult time. Training sessions were provided for staff in association with national bereavement charities and two bereavement newsletters were sent out in 2017. Specialist staff engaged with midwifery staff to improve the service. As a result, flowcharts were devised to assist staff when completing all of the paperwork and processes around fetal loss.

The service also maintained a mortuary fridge in a side room of the suite, which conformed to the guidelines of, and was monitored by the Human Tissue Authority (HTA). This meant women and their families could spend as much time as they wished with their baby without having to face the additional distress of visiting the mortuary. Staff were also able to discharge babies direct from the suite to undertakers or if parents wished to take their babies home for a time.

Parents were supported with making funeral arrangements where necessary and the bereavement team completed the paperwork, including cremation paperwork and medical examiners involvement. The hospital had a chaplaincy service, which offered support to parents who faced the loss of their baby. Chaplains and pastoral support for all various denominations and faiths or none were available on request. The service was sensitive to women’s cultural and spiritual needs for example they could organise ‘quick release’ discharges or shrouding ceremonies.

Staff told us they had plans to expand and improve the bereavement suite using charitable funds to provide a self-contained kitchenette and living area for families. They also hoped to create a soundproofed room on delivery suite so that women experiencing fetal loss who were labouring in that areas would not be further distressed by sounds from within that area.

Community midwives provided a programme of support for women and families including parentcraft classes, specialist teenage parenting group and a birth afterthoughts service.

**Bed Occupancy**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From April to June 2018 the bed occupancy levels for maternity was 68%, which was higher than the England average of 59%.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From January 2017 to March 2018 the bed occupancy levels for maternity were generally higher than the England average.
The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

**Meeting people’s individual needs**

The service took account of women’s individual needs

All women were assessed at booking for birth place choice. Community midwives supported and promoted home births. Between April 2017 and March 2018, 2.9% of all births at the trust were home births. This was below the trust target of greater than 3%. Some of these may have been unplanned home births (born before arrival, BBA) but had a midwife in attendance. Midwives and consultants developed and documented ‘wrap around the woman’ care plans for women who had been assessed as high risk but requested a home birth or a birth in the alongside midwife led unit.

Mental health and wellbeing was discussed with all women throughout pregnancy, and staff described an excellent level of support from the mental health midwife and perinatal mental health. These discussions included difficult and sensitive issues such as domestic violence, sexual abuse, drug use, female genital mutilation and child sexual exploitation.

An interpreting service was available for non-English speaking women and during the inspection we saw this in practice. Staff we spoke with knew how to access this. Important information was displayed in the antenatal clinic area, and we saw this had been translated into several languages, for example information about monitoring babies’ movement during pregnancy.

Women could choose from a range of meals including food suitable for specialist diets and cultural preferences, for example halal, vegan and gluten free.

**Access and flow**

People could mostly access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with good practice.
Women mostly had timely access to initial assessment, test results, diagnosis and treatment. This was in line with National Institute of Health and Care Excellence (NICE) QS22 statement 1. However, we did see women were waiting for long periods of time for appointments in antenatal clinic and for assessment in the PAER. In antenatal clinic women and visitors were having to stand as there were not sufficient chairs although the majority women and visitors were happy with the care they were receiving and told us they did not mind waiting to be seen.

Women assessed as high-risk women could access appointments at the Good Hope Hospital, Heartlands Hospital or the Women’s centre at Solihull Hospital.

Women could access the PAER 24 hours a day, seven days a week. Community midwives provided antenatal and postnatal care as required seven days a week and were on call to provide a home birth service always.

The antenatal and new-born screening for the whole trust was based from a hub at Heartlands Hospital. Staff within the team worked closely with fetal medicines midwives and consultants to see women referred to the team following an anomaly ultrasound scan within three working days.

**Closure of the maternity unit**

Data provided by the trust showed there had been no closures of the maternity unit to new admissions within the previous 12 months. Staff told us the service managed peaks of activity by diverting women as required between the two obstetric units at Heartlands Hospital and Good Hope Hospital.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

**Summary of complaints**

From April 2017 to March 2018 there were 11 complaints about maternity services across the trust as a whole. The trust took an average of 25.5 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be resolved within 30 working days.

Of the two complaints still open at the time of reporting both had been open longer than the trust target of 30 working days, the longest being open for 68 working days.

A breakdown by site is below:

- Birmingham Heartlands Hospital: There were five complaints, the themes were all aspects of clinical treatment with three complaints (60.0%) and communication/information to patients (written and oral) with two complaints (40.0%)
- Unspecified location: One complaint did not have the hospital site specified, this related to the antenatal clinic and was for all aspects of clinical; treatment

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From April 2017 to March 2018 there were seven compliments within maternity.

The breakdown by site is shown in the table below.
<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>3</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The service monitored complaints, concerns and compliments as part of the divisional clinical governance. We reviewed the Obstetrics and Gynaecology Quality and Safety meeting minutes from July 2018 and saw the complaint themes were included in the discussions.

Consultant midwives told us they number of complaints around birth plans and care in labour had reduced, especially since the introduction of specialist clinics to help support women with birth choices.

Is the service well-led?

Leadership

Staff did not always describe leaders and managers as visible and staff did not always feel supported.

University Hospitals of Birmingham NHS Trust provided maternity services as part of the Heartlands, Solihull and Good Hope (HSG) Division 2. Group A of the division included paediatrics, neonates, community school nursing, and health visitors. Group B of the division was gynaecology, obstetrics and community midwifery. Leadership of Division 2 was by the divisional director and, within group B, there were clinical service leads, one specifically for obstetrics. The head of midwifery (HOM) was also the divisional director of operations (DOO) and described her role as more strategic than operational. In addition, there was a divisional general manager and we saw these four key personnel worked closely as a team and communicated well.

The HOM was supported by a deputy HOM and a deputy DOO, a clinical midwifery manager (matron) for the delivery suite and a clinical services site lead (matron).

Most junior staff we spoke with did not describe the HOM as visible and approachable, however they did tell us the deputy HOM was more visible and this was in line with the HOM’s strategic role. Staff working in the hospital and community told us some of the middle managers were visible and supportive, however some individual managers were less so.

Staff working in both the hospital and community told us they did not always feel supported and valued by the senior leadership team.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, women, and key groups representing the local community.

The vision for the maternity service was aligned to ‘Better Births’, the report of the National Maternity Review, published by NHS England in 2016 and the Maternity Transformation Programme. Service leads told us of the work streams currently being undertaken, working with other providers and commissioners for Birmingham and Solihull United Maternity and New-born Pathway (BUMP). This collaboration also included local authorities and voluntary organisations in
the local maternity system (LMS). The vision for BUMP is that “Every woman will be empowered to access consistent, world-class and holistic care right for them, their baby and their family”.

Some of the aims and workstreams of BUMP include:

- Developing a single point of access for women in the region.
- Increasing the proportion of women choosing to give birth in midwifery led units or home births and supporting women to make informed choices.
- Creating a single maternity electronic patient record (EPR) for all pregnant women.
- Improving outcomes for women, their babies and families and the wider population which would also include a decrease in infant mortality.

One part of the joint strategy was to develop a single clinical governance system across the LMS by March 2019, which will include a systematic perinatal mortality review process. We reviewed the monthly highlight report for BUMP, which indicated progress against the project milestones. From that report we saw a joint BUMP approach to clinical governance had been developed and they were in the process of setting up a joint perinatal mortality review and significant clinical incident review group. This had been shared with the board sub-committees responsible for quality and safety within the BUMP providers and were awaiting feedback. They were also working on a joint maternity dashboard and were reviewing indicators and RAG (red, amber, green) ratings.

We saw a copy of the Midwifery strategy 2014-2019 was displayed in staff areas around the unit. Staff we spoke with were aware of the BUMP strategy.

**Culture**

Managers across the trust did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Services on all three sites and the community were run by one maternity management team. They were regarded and reported upon by the trust as one service. Whilst there were common governance and policies, staff reported there still felt a degree of separation in relation to the two main obstetric units. Staff we spoke with at Heartland Hospital told us they felt there was an inequality in the funding of the two sites, for example there were less electric ward beds at Heartlands Hospital. Some senior and specialist staff worked across all sites, however most midwives and doctors worked purely at the Heartlands Hospital. Service leads acknowledged this had been a challenge but were actively addressing it. They told us new consultants were appointed to trust wide posts, with the expectation they could work at both main sites. Video links were being used more often to encourage attendance at meetings and to avoid travel. Guidelines and equipment had been standardised to support staff rotating across the sites.

The staff we spoke with told us the needs and experience of the women was the most important element of their work, not all staff we spoke with felt supported, respected and valued. One theme around culture we heard was the lack of engagement or thanks from some managers. Some staff within the community did not feel they had a manager who was an advocate to promote improvements or who would escalate concerns.

We spoke to several staff members from all areas and departments, both clinical and administration, who reported elements of a bullying culture, primarily from middle management. Examples of this included staff on the wards and Pregnancy Assessment Emergency Room (PAER) who had experienced difficulties communicating with labour ward co-ordinators, leading to women being cared for in inappropriate clinical environments. Members of staff told us senior staff had reacted in a negative way when incident reports were submitted about staffing and had been
told not to submit further reports. However, some staff told us there had been improvements in the culture in recent months, previously there had been a ‘blame’ culture in relation to incidents, which was now less apparent.

We spoke with two domestic staff who had worked at the hospital for many years. They spoke of low morale because of staffing and pressure of work. They did not feel part of the team, were not included in any social functions and felt other staff only spoke to them if they were not doing a good job.

We escalated these concerns to service leads who were aware of some degree of an unsupportive culture but were not aware of the full extent of the problem. Service leads also acknowledged there had been difficulties developing the service as some of the senior medical staff were not as willing to embrace change. Staff gave an example of where changes to antenatal clinics would improve flow but had involved protracted discussions around job planning and rota changes. We were told improvements had been made in the culture with planned rotation of band seven midwives to work across both sites. It was hoped this would forge relationships and give a greater understanding of the demands of each area.

However, medical and midwifery staff we spoke with told us there was good multidisciplinary working and were proud of the service they provided. Junior doctors told us they were well supported by their seniors and by midwives on the unit. Midwives we spoke with told us the medical staff were approachable and they felt able to challenge decisions in women’s best interests. Staff told us they participated in charity activities for team building and to raise funds for the maternity unit. For example, we heard some of the staff climbed Snowdon to raise money for the Willow MLU.

**Governance**

We saw the service produced a quarterly divisional board quality and safety report and a quality governance report for obstetrics, which we reviewed. The reports summarised data collected from reported incidents, risks, guidelines and audit. We reviewed minutes of the Obstetrics and Gynaecology Quality and Safety group meeting from October 2018 and saw all aspects of governance were scrutinised, including incident reporting and management, infection prevention and control, complaints, friends and family data, clinical document control and the risk register.

At the time of our inspection there was 105 guidelines relating to maternity and 29 of those had passed the date for review. Service leads told us this was an improving picture. The service was working with other providers in BUMP to produce joint guidelines, which we were told made the process slower. The guideline’s midwife post had been funded for 18 hours per week by BUMP from November 2017, but the trust had not directly funded any hours. Since the new appointment at least 27 guidelines had been renewed and it was expected that all the guidelines would be in date by January 2019. However, this meant that we did not have assurance that all guidelines were in line with any new evidence or recommendations and women might be getting the safest and most effective care and treatment.

A variety of local clinical governance groups fed into monthly divisional meetings. Labour ward forum meetings were held monthly but were currently held separately for the obstetric units. We were told of plans to merge the meetings in the future. There were monthly cardiotocography (CTG) review, audit and mortality and morbidity meetings where specific incidents were reviewed by staff and senior leads. However, although midwives and labour ward coordinators we spoke with were aware these meetings were held, they told us they did not have time to attend and were not specifically allocated to attend on their rota.
Concerns, themes and trends were escalated to the monthly divisional quality and safety and operations board meeting and upward to the executive board through the corporate clinical monitoring group.

Management of risk, issues and performance

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected, however these were not always robust.

The service monitored a range of quality and performance measures through ward metrics. Performance was assessed monthly and included medication assessments, infection control, privacy and dignity, post-natal, fluid balance and bladder assessments, pain, communication, assessment of the newborn and equipment checks. The trust supplied data relating to the ward metrics, however the data was not labelled therefore we were unable to ascertain what ward they related to. However, we were not assured of the robustness of the oversight and auditing of cleanliness in view of the areas of concern identified on inspection.

The trust operated a corporate risk register, which incorporated the ongoing risks identified for the maternity service. Risks were entirely recorded and managed using the trust’s electronic incident reporting system. At the time of our inspection the division had recorded five risks for obstetrics and one for community midwifery. Of the total obstetric risks recorded, two were trust wide and included reduced capacity in ultrasound and inadequate provision of training and equipment for the electronic record system. Risks specific to Heartland Hospital included lack of capacity within the PAER and compromised quality of care for high risk women at their initial consultant appointment in antenatal clinic. Service leads told us this register was a ‘live’ register as some risks were managed and controlled so were not included on the register. One example of this was staffing, which was a risk, but was managed and controlled through escalation.

The service recorded how long each risk had been on the register, there were three risks that had been on the register since 2016, the oldest was from April 2016. Service leads acknowledged that some risks had taken a long time to resolve. For example, the prevailing culture amongst consultants had made it more challenging to resolve the difficulties in antenatal clinic. However, the service had obtained funding for additional equipment for community midwives to make access to the electronic record more efficient and would shortly be ordering mobile equipment.

We reviewed minutes of the Obstetrics and Gynaecology Quality and Safety meeting from October 2018. We saw the current risks were listed and there were discussions in the minutes about actions taken and review of the risks. We saw details of the risk register were shared with staff; there were copies of the Divisional Risk Profile in ward areas and communication folders. We saw a one page ‘snapshot’ of the obstetric dashboard was produced and displayed every month. Data included birth statistics including type of birth and complications rates such as perineal trauma and babies unexpectedly admitted to the neonatal unit.

We reviewed the report to the Obstetrics Quality and Safety group from July 2018. This interim report identified nine workstreams that had been introduced to improve the quality and safety of maternity care which included; surgical site infection, learning from excellence, neonatal hypothermia/hypoglycaemia (cold/low blood sugars), category one caesarean section, cervical sweeping in high risk women, induction of labour and fetal monitoring. The report gave details of the aims of the projects, progress to date and the next steps.

At the time of our inspection there was one risk midwife, trust wide. Service leads acknowledge this was not sufficient for the level of work generated across all three sites, and a further risk midwife had been appointed and would be in post by January 2019.
Staff told us all incidents were reviewed daily by senior staff. In addition, there was a weekly obstetrics and gynaecology risk meeting (CIRG), attended by the clinical service lead and a senior midwifery lead who reviewed all incidents raised within the service. Potentially serious or high-risk incidents were scoped within 72 hours and reviewed by the divisional director, clinical service lead and head of midwifery, and any immediate actions taken as required. These incidents were discussed at the Clinical Professional Review of Incidents group (CRIP) who would confirm whether it was a serious incident and whether an investigation and root cause analysis was required. Service leads explained they considered the grading of all incidents but any incidents where there was no “avoidable” harm were likely to be downgraded to low or no harm. We could not be assured that incidents were graded appropriately according to harm.

We saw incident themes and trends, together with any actions arising from completed or ongoing investigations were discussed at the divisional quality and safety meetings.

An audit trail of all actions taken in relation to any incidents was kept in the electronic incident reporting system, and staff had to complete the “lessons learned” section within the electronic record.

The service maintained a maternity quality dashboard, called the HGS (Heartlands, Good Hope and Solihull) Obstetric Indicators, which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. In addition, the service was working with other providers in the local maternity system, the Birmingham and Solihull United Maternity and New-born Pathway (BUMP) to create a joint local maternity system (LMS) dashboard. During our visit to the Good Hope Hospital, we saw the dashboard data was split by site. Following the inspection, we requested a copy of the dashboards, split by site, however the trust provided the HGS and the LMS dashboards for the service as whole. We reviewed both dashboards and saw there was discrepancies in the data therefore we did not have assurance about the oversight of this data.

Managers on the Willow MLU told us they had made improvements in the inputting of data into the trust inpatient system that monitored bed state and would be used in the event of a major incident such as a fire. The MLU did not have a ward clerk and staff had been failing to input admissions, transfers and discharges in a timely fashion. The responsibility for inputting this data lay with the midwives. A system had been introduced for two hourly reviews of the system and the data was now more robust.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The maternity service collected data around patient activity and outcome. Clear service performance measures were reported through the maternity dashboard, this included red, amber, green ratings to enable staff to identify metrics that were better or worse than expected.

Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible through the trust’s intranet facility. There was sufficient access to computers on the wards. Staff had access to the women’s records and diagnostic tests that they needed in a timely way.

The trust was moving towards an integrated electronic patient record system which would incorporate antenatal, intrapartum and post-natal care for women. This was part of the strategy for BUMP. Service leads told us there was a plan for all records to be kept electronically by Spring 2019. One of the key deliverable outcomes of the Birmingham & Solihull United Maternity and
Newborn Partnership (BUMP) was for ‘all women would have a single, electronic personalised care plan that they have full access to by December 2018’. We reviewed the bi-monthly progress of BUMP and saw they were on track to meet this milestone. Other providers across BUMP would also be using the same system which would allow better sharing of information.

Arrangements to ensure the confidentiality of identifiable data were generally robust. Across all clinical areas we saw medical records were always secured in a locked trolley or stored in a secure area where staff were working. However, we saw computers were not often left logged on or visible, particularly in the PAER area.

Engagement

The trust engaged well with women, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service engaged with women and the local community through their work with BUMP. Women’s views were fundamental to the overall evaluation of the BUMP workstreams and were being collected in a variety of ways including the use of social media.

Women’s feedback was generally obtained through the NHS Friends and Family test (FFT). In addition, all the wards we visited displayed ‘thank you cards’ from women and members of the public. We saw ‘How did we do?’ displays on the Willow MLU to encourage women and their birth partners to feedback on the service and suggest changes. We saw feedback from women who valued the opportunity to visit the MLU and speak to staff prior to going into labour.

Specialist staff engaged with staff to improve the service. For example, we were told flowcharts had been devised to assist staff when completing all the paperwork and processes around fetal loss.

Wards and departments held staff meetings on a regular basis, to share learning and highlight areas for improvement, which staff told us was useful and they attended when they were able.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Practice development midwives told us and we observed they had made innovations to the training programme to make the sessions more interactive and engaging for staff, using games and different learning styles and mediums. The training was to be evaluated to assess how effective it was.

The service introduced a 34 week of gestation review clinic in the Willow midwife led unit (MLU) in February 2018. Midwives gathered women’s feedback and evaluated the effectiveness of the clinic for three months and presented the findings to the delivery suite forum and team meetings. Feedback from women who accessed the clinic was positive and reduced anxiety around coming into hospital in labour.

Two midwives had completed an accredited training course and it was planned to offer aromatherapy to women in labour on the Willow MLU from 2019. Staff were working with pharmacy and clinical governance to produce guidelines. Aromatherapy is a complimentary therapy which may aid relaxation and reduce stress and anxiety in labour and is often used as an alternative to more traditional forms of pain relief.

Staff told us the service was part of the first wave of NHS Improvement Maternal and Neonatal Health Safety Collaborative and were using quality improvement methodology to improve
outcomes for women and babies. As part of this process the service used a process across all maternity sites called ‘Learning from Excellence’ (LFE) to encourage staff to nominate their colleagues when they recognise excellent work or practice. This process meant staff received praise from their peers and allowed others to learn and share good practice. At the time of our inspection, staff were completing paper forms, but it was hoped this would soon be electronic. Staff told us 389 LFE nominations had been received since it was introduced as a pilot in April 2017. Each person nominated received a certificate.

The service won the Royal College of Midwives ‘Sands Bereavement Care Award’ in 2017 and one of the specialist midwives also won a ‘Who cares Wins’ award in October 2018, promoted by a national newspaper.
Acute services Good Hope Hospital

Urgent and emergency care

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We visited Good Hope Hospital as part of the inspection process and this appendix relates to that site.

Good Hope Hospital was situated in Sutton Coldfield. Sutton Coldfield had constituency that was less ethnically diverse, than the Birmingham as whole with 88% of the working age population being from a white background compared to 59% for Birmingham. 81% of the working age population were economically active and 74% were employed well above the rates at a city level.

None of Sutton Coldfield's population lived in deprived neighbourhoods, compared to 40% for the city. Deprivation levels were very low in all Sutton Coldfield wards, although Sutton Trinity had slightly higher levels than the other three wards.

Sutton Coldfield had a higher older population with 23% of Sutton Coldfield population aged 65+ compared to 12.7% in Birmingham.

(Source: Birmingham City Council: Sutton Coldfield Economic and Employment Profile)

At Good Hope Hospital, the majors' department within the emergency department operated 24 hours a day, seven days a week. This department dealt with patients with severe injuries who were likely to require admission to the hospital. There were 19 cubicles, three of which were dedicated to assessing patients on their arrival.

There was a minor injury (minors) department for patients who needed some investigation or treatment for an injury but were unlikely to be admitted. This had seven cubicles and was open from 7am to 3am.

Life threatening emergencies were dealt with in the resuscitation room. These patients were normally brought in by ambulance from the front of the building. The resuscitation room had five beds of which one was a child's (paediatric).

The clinical decision unit had four beds and seating. This was a designated area within the hospital that allowed the service to monitor and evaluate the medical condition of patients who did not meet criteria for inpatient admission but were not well enough to go home without requiring further observation.

The service had primary care stream consisting of a ‘GP in ED’ service which operated from 11am to 7pm Monday, Tuesday and Wednesday.
There was also an out of hours GP deputising service (BADGER) that operated from within the hospital site from 6.30pm to 10.30pm Monday to Friday and 10am to 10pm at weekends and Bank Holidays. Patients could be transferred to this service following initial assessment if they meet the agreed criteria. A clinical navigator was based in minors and triaged all ambulant patients presenting in minors to the correct stream to ensure the patient is seen in the correct stream for their clinical needs.

(Source: Acute PIR – Context acute QEB / Context acute HGC tabs)

Details of emergency departments and other urgent and emergency care services

- Queen Elizabeth Hospital – Emergency department and clinical decision unit (CDU)
- Birmingham Heartlands Hospital – Emergency department and ambulatory care
- Good Hope Hospital – Emergency department and ambulatory care
- Solihull Hospital – Ambulatory emergency care

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Note where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Heart of England NHS Foundation Trust

Total number of urgent and emergency care attendances at Heart of England NHS Foundation Trust compared to all acute trusts in England, August 2017 to March 2018

From August 2017 to March 2018 there were 179,805 attendances at the trust’s urgent and emergency care services as indicated in the chart above. Of these 153,728 were type 1 and 26,077 were type 3.
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission remained similar between 2017/18 and 2016/17. In both years, the proportions were higher than the England averages.

Urgent and emergency care attendances by disposal method

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Urgent and emergency care attendances by disposal method, from June 2017 to May 2018
* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff but not everyone had completed it.

Not all medical and nursing staff were up to date with their mandatory training for safety systems, practices and processes. Training was provided both face to face and online. Staff we spoke with said that they found the training to be relevant and interesting. The trust met the 90% target for nine of the 12 modules applicable for nursing staff. All modules had a completion rate of over 80%. The trust met the 90% target for six of the 12 modules applicable for medical staff. Staff were sent an email alerting them when training was due. Whenever possible team leaders would book staff on to future courses.

A breakdown of compliance for mandatory training courses from April 2018 to June 2018 for qualified nursing staff in urgent and emergency care at Good Hope Hospital is shown below. This information was routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>65</td>
<td>65</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>65</td>
<td>66</td>
<td>98%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste Management</td>
<td>65</td>
<td>66</td>
<td>98.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>65</td>
<td>66</td>
<td>98.5%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>64</td>
<td>66</td>
<td>97.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>63</td>
<td>66</td>
<td>95%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>62</td>
<td>66</td>
<td>94%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>62</td>
<td>66</td>
<td>93.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual Handling - Patient Handling</td>
<td>61</td>
<td>66</td>
<td>92.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>59</td>
<td>66</td>
<td>89.4%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>58</td>
<td>65</td>
<td>89.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
A breakdown of compliance for mandatory training courses from April 2018 to June 2018 for medical staff in urgent and emergency care at Good Hope Hospital is shown below. This information was routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major Incident Awareness</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>4</td>
<td>6</td>
<td>67%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Patient Handling</td>
<td>3</td>
<td>6</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Waste Management</td>
<td>2</td>
<td>6</td>
<td>33%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Clinical</td>
<td>2</td>
<td>6</td>
<td>33.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Although data showed that neither medical or nursing staff met the trust target for resuscitation training, all staff told us they had received the training. Staff we spoke with said that they had received basic life support and when applicable advance life support including paediatric life support. This could not be evidenced by the trust’s data return which detailed low completion rates for the resuscitation module and did not detail the service’s training compliance for advance life support including paediatric life support.

Although the trust did not provide specific mental health conditions, learning disability or autism needs training, staff understood how to treat a patient with those needs. Staff could describe what they would do if a patient had mental health or other specialist needs. Staff knew who the trust leads were and could access the local Rapid Assessment Interface and Discharge (RAID) team. The RAID team was provided by a local mental health trust to provide specialist mental health assessment to patients presenting having self-harmed, used alcohol and drugs in a harmful hazardous way or who had mental health difficulties associated with old age.
Dementia training was covered within a small section of the trust’s corporate induction and staff had the option to attend an additional full study day on dementia as part of their development. The hospital had a dementia lead who was available to provide onsite advice. Staff we spoke with said that the team were looking to introduce the ‘this is me’ passport; a nationally recognised form used to provide details about a person living with dementia. The form included details on the person’s cultural and family background; events, people and places from their lives; preferences, routines and their personality.

Sepsis management training and information was of a high standard combing online and face to face modules; including the use of sepsis screening tools and the use of sepsis care bundles. Staff we spoke with said they had attended sepsis training and that this was supplemented by ad hoc on the shop floor training. The trust had a sepsis lead who could be accessed onsite for additional advice. The trust had a sepsis policy and staff could access this online via the trust’s intranet. We saw sepsis pathways documented on modified early warning scores (MEWs) and paediatric early warning scores (PEWs) documentation.

(Source: Trust routine provider information return and DR179)

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.

Nursing staff received and were up to date with their mandatory training for safeguarding. The trust met the 90% target for three of the four modules. All staff we spoke with said they had completed Safeguarding Level 3 Children Core Knowledge but the trust’s pre-inspection data submission did not evidence this.

A breakdown of compliance for safeguarding training courses from April 2018 to June 2018 for qualified nursing staff in urgent and emergency care at Good Hope Hospital is shown below. This information was routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Nursing staff - April 2018 to June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding Level 1 Children and Adults</td>
<td>65</td>
</tr>
<tr>
<td>Safeguarding Level 2 Children and Adults</td>
<td>3</td>
</tr>
<tr>
<td>Healthwrap PREVENT</td>
<td>63</td>
</tr>
</tbody>
</table>

Medical staff received and were mostly up to date with their mandatory training for safeguarding. The trust met the 90% target for two of the four modules. The trust did not meet the 90% target for PREVENT training but this equated to one staff member. PREVENT focuses on all forms of
terrorism and operates in a 'pre-criminal' space'. The strategy is focused on providing support and re-direction to individuals at risk of, or in the process of being groomed /radicalised into terrorist activity before any crime is committed. Radicalisation is comparable to other forms of exploitation; it is a safeguarding issue that staff working in the health sector must be aware of.

A breakdown of compliance for safeguarding training courses from April 2018 to June 2018 for medical staff in urgent and emergency care at Good Hope Hospital is shown below. This information was routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Level 1 Children and Adults</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Level 2 Children and Adults</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthwrap PREVENT</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Post the inspection we requested an updated copy of the safeguarding training compliance rates for Good Hope Hospital. The trust were unable to provide this by site. The figures below show the total compliance rate for Good Hope Hospital, Heartlands Hospital and Solihull Hospital. This evidence backed the staff’s assertion that training had been received.

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Staff required to undertake the training</th>
<th>Total staff</th>
<th>Number trained</th>
<th>Target</th>
<th>Current Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children &amp; Adults Level 2</td>
<td>HCA’s; Emergency Practitioners &amp; Junior Medics</td>
<td>309</td>
<td>284</td>
<td>85%</td>
<td>92%</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Adults Level 2 within 3 yrs</td>
<td>HCA’s; Emergency Practitioners, Junior Medics, Qualified Nurses &amp; Senior Medics</td>
<td>309</td>
<td>274</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>Qualified Nurses &amp; Senior Medics</td>
<td>207</td>
<td>194</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Children Level 3 within 3 yrs</td>
<td>Qualified Nurses &amp; Senior Medics</td>
<td>207</td>
<td>189</td>
<td>91%</td>
<td></td>
</tr>
</tbody>
</table>
The service ensured that staff had access to timely safeguarding advice and support. Staff told us that the trust safeguarding lead would visit the department weekly and do additional training and that they had access to online video training. The trust had a named safeguarding lead and staff knew how to access them for advice. Staff could attend a trust wide study day on mental health including adolescent mental health which covered a range of topics including depression and self-harm. Staff could access the local Rapid Assessment Interface and Discharge (RAID) team who would attend on site within an hour.

Staff knew and could explain to us their responsibilities in relation to how to recognise and report different forms of abuse, including domestic violence, female genital mutilation (FGM). Staff had access to trust wide safeguarding policies and procedures for safeguarding adults and children. Contact numbers for support were readily available in the department and displayed on posters and leaflets. Staff could access policies and procedures through the trust's intranet.

Staff checked the child protection information sharing system (CPIS) for any patient aged 18 or under and alerted staff if the child was known to have a child protection plan in place or was a looked-after child. The system automatically flagged a known child’s attendance at the department to the relevant social worker. The service’s electronic patient record system flagged if a child was thought to be at risk of child sexual exploitation or was a frequent attender; which could indicate abuse. Staff we spoke with said that if they suspected or believed that a child was suffering or was likely to suffer significant harm or any form of mistreatment or abuse, then they would report their concerns immediately to the Children’s Advice & Support Service (CASS).

The trust had a rapid tranquilisation policy and process but not all staff were aware of this policy or the process. Senior staff stated that this policy had recently been updated following discussion with the RAID team.

(Source: Routine Provider Information Request (RPIR) and DR329)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Although hand hygiene audit results showed a declining picture, staff followed infection control and hygiene procedures. We saw an information board located between majors and minors which detailed the latest service hand hygiene audit results; July 2018 92%, August 2018 80% and September 70%. Staff we spoke with said they were not sure why the results had declined but believed in part it was due to a heavy workload with limited time.

The trust submitted their care indicator results summary which contained data pertaining to Good Hope Hospital, Heartlands Hospital and Solihull Hospital (HGS). From March 2017 to September 2018, the emergency departments together scored from 92% to 97% for environment; this included hand gel being available, cubicle cleaned in-between patients, resus areas clean and infection control.
We saw staff were bare below the elbow and saw frequent hand washing pre and post treatment. Each cubicle was equipped with a washbasin, hand wash and protective personal equipment such as gloves and aprons. We saw staff use protective equipment appropriately.

Although antibacterial hand gel was available in every cubicle for staff to use, there was limited opportunity for visitors to the department to use hand gel. There was one dispenser within the minors waiting area and on the inspection, we found this to be empty with a torn out of use sticker on it. We raised this with the reception staff and they contacted housekeeping who replaced the dispenser within 15 minutes. In the corridor from the minors waiting area to majors and the paediatric emergency department there were no gel dispensers. We questioned this with the senior sister who said that this was mitigated by staff members carrying individual hand gels however, they agreed that this did not always happen. Later that day we saw temporary hand gel dispensers had been supplied next to the entrance.

Staff kept the department and equipment visibly clean. We saw ‘I am clean’ stickers on equipment which detailed the date it was cleaned. The service had a dedicated housekeeper onsite and we saw that they cleaned each cubicle after use. In minors, we saw housekeeping deep clean the plaster room after use. We viewed cleaning logs, including logs for cleaning toys, and saw that they were up-to-date and completed appropriately.

(Source: Trust data return DR174)

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.**

The service designed the layout so it was suitable for patient needs and supported patient flow. The minors, majors and paediatric emergency departments were situated within the same area. The resus area was situated between majors and paediatrics allowing both areas easy access, with the paediatric bed being located next to the paediatric entrance. The paediatric emergency department was kept separate from the adult areas and had its own waiting area. This was in line with the intercollegiate document for children and young people in emergency care settings (2012). The waiting area for children included seating, signage regarding parental roles and responsibilities and some toys for younger children in the children’s area.

The emergency department x-ray was situated across the corridor providing quick and easy access and additional services such as computerised tomography (CT) and magnetic resonance imaging (MRI) were a short walk away. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body and CT scan uses X-rays and a computer to create detailed images of the inside of the body.

Access to the paediatric emergency department was through a locked door accessed through video feed into the nurses’ station. Majors and minors were accessible to the public between 7am and 10pm after which the doors were locked and only accessed by buzzer.

Equipment was well maintained. The trust kept a database with maintenance schedules in line with manufacturer’s instructions. We saw that equipment safety test dates were all in date for safety checks including a label for their review date. Staff told us the medical equipment team were available to check and repair equipment when necessary and the staff labelled any equipment not for use and removed this to a safe area until collection. Staff always had access to
clean linen and staff removed dirty linen at regular intervals from the departments and cubicles after use by patients.

The trust submitted their care indicator results summary which contained data pertaining to Good Hope Hospital, Heartlands Hospital and Solihull Hospital (HGS). From March 2017 to September 2018, the emergency departments together scored from 92% to 97% for environment; this included resus areas checklists - last 30 days, defibrillator working and equipment trays. Staff ensured that resuscitation equipment was available and fit for purpose. There were five resuscitation bays with one dual used bay in resus, equipped for adults and children, that was fully equipped with resuscitation equipment for children with all sizes of equipment. Adult resuscitation equipment was available and fit for purpose, being adequately stocked. We saw that equipment had been checked regularly and saw evidence of audits. Staff maintained a daily check of resuscitation, sepsis, and airways trolleys, and we found these well maintained with minimal gaps in staff records.

Although there were facilities for conducting mental health assessments, improvements could be made. An environmental assessment of the hospital’s psychiatric room showed that it had a few ligature points and was very bare with minimal furniture. The room had two exits/entrances and was monitored by CCTV which could be seen from the nursing station but had lots of blind spots. The staff mitigated those blind spots by allowing relatives, carers and friends to sit with the patient whilst doing additional patient observations.

(Source: Trust data return DR174)

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient. They asked for support when necessary.**

**Emergency Department Survey 2016 - Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust scored about the same as other trusts for all of the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q33. In your opinion, how clean was the emergency department?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.5</td>
<td></td>
</tr>
</tbody>
</table>

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>About the same as other trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9.7</td>
<td></td>
</tr>
</tbody>
</table>

**Median time to initial assessment**

The median time from arrival to initial assessment was worse than the overall England median from October 2017 to September 2018. Data for October 2017 to March 2018 was provided for contextual purposes and it did not form part of our judgement.

**Percentage of ambulance journeys with turnaround times over 30 minutes**

From October 2017 to September 2018, there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Good Hope Hospital. However, only one month dropped below 90%.
There was a clear ambulance handover process. Ambulance staff would hand over to designated nursing staff in a private environment. They would complete a proforma which required sufficient details such as patient observations and medications, to ensure a safe transfer. Once transferred the patient would then be assessed by a designated assessment nurse in one of the three assessment cubicles. If a cubicle wasn’t available patients would wait on the corridor until one became available.

**Good Hope triage times**

Trust data showed that the majority of patients were triaged within 15 minutes.

<table>
<thead>
<tr>
<th>GOOD HOPE</th>
<th>Time to Triage &lt;15mins</th>
<th>Time to Triage 15-30mins</th>
<th>Time to Triage 30-60mins</th>
<th>Time to Triage &gt;60mins</th>
<th>Time to Clinician &lt;60mins</th>
<th>Time to Discharge &lt;4hrs</th>
<th>Left before being seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majors</td>
<td>3537</td>
<td>33%</td>
<td>19.90%</td>
<td>25.10%</td>
<td>22%</td>
<td>36.10%</td>
<td>56.90%</td>
</tr>
<tr>
<td>Minors</td>
<td>1818</td>
<td>81.80%</td>
<td>4.68%</td>
<td>6.88%</td>
<td>6.64%</td>
<td>39.20%</td>
<td>96.50%</td>
</tr>
<tr>
<td>Paeds</td>
<td>1348</td>
<td>46.20%</td>
<td>26.90%</td>
<td>20.70%</td>
<td>6.20%</td>
<td>33.40%</td>
<td>92.90%</td>
</tr>
</tbody>
</table>

The service had a clear triage process in place. Staff were allocated specific roles at the beginning of each shift. Patients registered into the emergency department would receive a nurse-led initial assessment and triage which would then identify the most appropriate area for patients to be seen. Triage enabled identification of patients at risk of developing sepsis, patients with head injuries or other trauma related injuries.

Risk assessments for pressure ulcer and falls assessments were carried out. The service also screened patients for frailty and referred them to the trust’s frailty team. However, high
specification mattresses were not provided for all trolleys in the department but were on order. These mattresses reduced the likelihood of pressure ulcers developing.

The service ensured effective sepsis screening was undertaken and the sepsis pathway commenced at patient triage. Ambulance staff pre-alerted the service for any patients thought to be at risk of, or were showing symptoms of the development of sepsis. The department used a modified early warning score system in conjunction with its escalation plan to ensure that deteriorating patients were appropriately escalated to medical staff. Staff used an age-appropriate early warning system for paediatric patients. The service also had four dual trained consultants; trained to treat adults and children, this was a good skill mix. The service ensured that there was paediatric cover always.

The service had robust processes for referring patients presenting with mental health illnesses. Patients were referred to the local Rapid Assessment Interface and Discharge (RAID) team who attend within one hour. The RAID team could refer the patient onwards for psychiatric assessment or medicine prescription, and provided advice to department staff on the patient’s care plan.

Staff could use the enhanced observation care bundle on any patient and this was effective for mental health and patients living with dementia. This bundle was comprehensive and included additional information and prompts around physical description, individuals mental state and risk assessments. The bundle also had a modified SAD personas score (this assessed if a patient was at risk of suicide) and highlighted child protection issue and the conditions forensic history. The bundle included the missing patient procedure and safe management of confused patients.

Senior leaders acknowledged that local and national shortages of mental health in-patient beds had a significant impact on the department as patients could wait excessive amounts of time for a bed to become available. This was on the risk register, and the service was working with the local mental healthcare provider to improve the quality of care for mental health patients.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017, Trust data return DR330 and DR338)

Nurse staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

Although the service did not have a full establishment of qualified nursing staff, it had implemented mitigation to ensure the service staffing levels could meet the needs of the patients. Good Hope Hospital reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in urgent and emergency care. The overall fill rate for qualified nursing staff increased from 78.1% in March 2018 to 80.1% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>59.8</td>
<td>76.5</td>
</tr>
</tbody>
</table>
Staffing levels were reviewed to ensure they were safe and at the time our inspection, staffing was appropriate to meet the needs of the department. The high level of nurse vacancies and skill mix were on the trust’s divisional risk register.

The service implemented change effectively to combat high vacancy and turnover rates. From April 2017 to March 2018, Good Hope Hospital reported a vacancy rate of 21.5% and a turnover rate of 24.6% for nursing staff in urgent and emergency care. This was higher than the trust target of 5% vacancy and 8.5% turnover.

Staff we spoke with said they believed that the high vacancy and turnover was due to several staff leaving during a period in the previous year when morale was low. Staff had also fed back that they had left the service due to inflexible shifts, as a result the leadership team reworked the rota to offer five hour shifts to accommodate staff with carer responsibilities.

Additionally, the team had introduced changes such as developing their band seven nurses to oversee a specific area such as training or staffing; this ensured a comprehensive oversight. The team had worked together to reduce the number of serious incidents in the service and had implemented new responsibilities such as corridor nursing. Staff felt that the vacancy and turnover rates had lowered over the last 12 months and morale was improving.

The staffing shortfall was mitigated by block booking agency nursing staff. The service used the same agency provider and many agency staff regularly worked on the department. Agency staff we spoke with said they felt like part of the team and were treated the same as permanent staff. They received the same training and support. Staff we spoke with said that the agency usage was high with some days being filled by 60-70% agency staff but that the service was safer as a result. However, there was concerns that agency staff could not be booked with less than 48 hours’ notice which meant occasionally some shifts would not be filled. This meant that some shifts would not have the recommended number of qualified nursing staff to treat patients.

Emergency department staff would also assist in supplementing the staffing short fall by working bank shifts; these were additional shifts to their standard working work. However, the bank pay rates had recently been reduced following a review and as such the number of staff working bank had reduced.

From April 2017 to March 2018 the trust reported that for qualified and unqualified nursing staff 8.2% of actual hours were filled by agency staff and 20.2% by bank staff across Birmingham Heartlands, Good Hope and Solihull hospitals. The number of unfilled hours, a breakdown by site and staffing type was not provided.

Staff ensured that nursing handovers were comprehensive and provided continuity of care. Each shift had a full handover within the staff room at which patient information and clinical governance messages were disseminated. This was then followed by a shop floor handover where nurses staffing levels were discussed at handover and as part of the situation background report (SBAR). We observed a nurse handover and the shift coordinator checked that staff had the necessary skills and experience to carry out duties in the ED and deployed them accordingly, for example to majors or minors.

Service leaders recognised that there were a lot of new starters and were actively considering their wellbeing to support them. The service had recently recruited 15 new nurses, all of whom
would receive a four-week supernumerary period; this period was to allow adequate time for registered nurses to develop basic skills and competencies to safely care for a patient. They had developed a new induction that introduced new starters to each area by allocating them a three-month period in each area after completing a study day.

(Source: Routine Provider Information Request)

**Medical staffing**

The service did not always have enough medical staff to keep patients safe and provide the right care and treatment.

Although the service did not have a full establishment of medical staff, staff worked as a team to ensure the service was safe. Good Hope Hospital reported their staffing numbers below for March 2018 and June 2018 for medical staff in urgent and emergency care. The overall fill rate for medical staff decreased from 72.7% in March 2018 to 54.5% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
<td>Fill Rate</td>
<td>Actual staff – WTE in month</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>8.0</td>
<td>11.0</td>
<td>72.7%</td>
<td>6.0</td>
</tr>
</tbody>
</table>

The service did not meet the Royal College of Emergency Medicine (RCEM) guidance which recommended the service had 25 consultants. At the time of reporting, there were 20 consultants employed by the trust who worked across the different hospital sites, with an additional three waiting to take up post. RCEM also recommended that consultant rotas should be covered for 16 hours each day and we saw that the service did not meet this; the rota covered 14.5 hours. However, updated RCEM recommendations had only been published in September 2018, a few weeks before our inspection. Staff we spoke with said that consultant cover was provided on site between 8am and 10pm daily, and although there was no specialist ED consultant cover throughout the night, other consultants with appropriate competencies were available on call always.

Staff also said that consultants would regularly work over their hours and would also step down to a junior grade rota to help fill the gaps. This meant that the service was safe as it was being managed by the staff but could become unsafe if staff became unwell or left.

The trust was actively recruiting to fill the vacancies and staff felt that the challenge was finding suitable applicants.

From April 2017 to March 2018, the trust reported a vacancy rate of 40.6% for medical staff in urgent and emergency care. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request)

**Records**

Staff did not always keep detailed records of patients’ care and treatment. Records were not always clear or up-to-date but were easily available to all staff providing care.
Records were securely stored and easily accessible. The service used a combination of electronic and paper based records to monitor patient safety and treatment. The paper records contained observations and notes.

Although records were not consistently completed, the service scored well in their internal audit. We reviewed 15 sets of records and found not all records were completed in full. We could not find evidence of discussions with patients in seven sets of records. However, we did evidence that the mental health team and emergency department staff recorded in the same patient notes and verbally handed over to each other which was good practice.

In one set we saw the patient had been brought to the emergency department after having a fall but could not find any evidence of a falls assessment. We spoke with staff and were told that an elderly care proforma should have been completed which included a falls assessment. We then saw staff complete the proforma. Additionally, we reviewed a patient record that had an enhanced observation care bundle in place and found that that the bundle had not been completed in full; this included a higher level of patient detail and included a SAD PERSONAS score; an acronym based on 10 suicide risk factors and was used to assess the likelihood of a suicide attempt. We raised this with the senior sister and were told that the member of staff in question would receive additional support to complete the document.

After the inspection we requested a copy of the latest record audits and received a copy of the emergency department metrics for Good Hope Hospital, Heartlands Hospital and Solihull Hospital (HGS) combined. For September 2018 in the metric medication assessment HGS scored 86% for allergy status signed, 83% intra venous fluids administered in time, and 100% for legible prescriptions, observation chart details and prescription chart details.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>April 18</th>
<th>May 18</th>
<th>June 18</th>
<th>July 18</th>
<th>Aug 18</th>
<th>Sept 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resus Checklist</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Allergy Status Signed</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>88%</td>
<td>75%</td>
<td>88%</td>
</tr>
<tr>
<td>IV fluids administration time</td>
<td>100%</td>
<td>100%</td>
<td>75%</td>
<td>60%</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>Legible Prescription</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td>67%</td>
<td>100%</td>
</tr>
<tr>
<td>Observation Chart details</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>Prescription Chart details</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Demographics on MEWS / PEWS chart</td>
<td>100%</td>
<td>90%</td>
<td>89%</td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>Escalation if Score 4 or More</td>
<td>100%</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Frequency of Observations</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>
Senior sisters would perform spot check of eight records in each shift, to assess their quality and we saw this evidenced on the quality and safety sheet.

(Source: Trust data return DR174 and DR339)

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Staff ensured that medicines were stored securely within the emergency departments. Drugs cupboards and fridges were locked with a key and housed within rooms that required key coded access. We saw evidence of regular daily checks and stock balances were correct. Controlled drugs were appropriately stored with accurately maintained records and restricted staff access. Under the Misuse of Drugs legislation some prescription medicines were called controlled medicines or controlled drugs, for example morphine and required stricter legal controls on how they could be stored and prescribed.

On inspection it was reported that the controlled drugs book had gone missing from majors. We saw that staff responded to this appropriately by contacting pharmacy for support, who in turn had stopped all orders from the book’s serial number and an incident report had been raised.

Although drugs fridge temperature checks were not always in line with guidelines staff followed the appropriate escalation guidance. Staff we spoke with said that the paediatric emergency department drugs fridge was regularly showing a higher maximum temperature than recommended. Staff had escalated this to the pharmacy team and new probe had been installed and medicines were checked. However, this issue was still ongoing and staff again raised this as a concern to the pharmacist team. All staff we spoke with said they had received training on how to escalate concerns and knew when and how to contact pharmacy for support.

Staff ensured that emergency medicines were readily available on emergency trolleys. These were stored within clip locked boxes and secured with a cardboard seal; this indicated the drugs had been checked by a pharmacist and were intact. Intravenous fluids were clearly labelled and stored appropriately. The trust pharmacy team checked the controlled drugs regularly as part of their ongoing quality monitoring processes.

Staff documented allergies as required within patient records. In the 15 medication records we reviewed, staff had completed patient allergies to medicines if known. We saw patients wearing a red wrist band which indicated that the patient had an allergy.

Staff had 167 Patient Group Directions (PGDs) to refer to of which 21 were outside of their review date some as much as five years; Phyto menadione Vitamin K review date 30/11/2013. PGDs
were a legal mechanism that allowed certain health care professionals for example, nurses to supply and or administer medicines to certain patients without a prescription. Staff used PGDs in the ED to supply patients with medicines in a timely manner for example, pain relief. We spoke with a trust pharmacist during our inspection, who told us the trust were in the process of reviewing all PGDs with a view to aligning them across all trust hospital sites.

After the inspection we requested a copy of the hospital's latest medicines management audit but the trust was unable to supply this data. The trust did submit their care indicator results summary which contained data pertaining to Good Hope Hospital, Heartlands Hospital and Solihull Hospital (HGS). From March 2017 to September 2018, the emergency departments together scored from 92% to 97% for environment; this included IV fluids in secured areas, resus bay drugs, CDs daily checking and keys kept separate, fridge temperatures and secure medicines/cupboard.

(Source: Trust data return DR173 and DR174)

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents 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.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The trust reported no incidents classified as a never event for urgent and emergency care at Good Hope Hospital occurring from August 2017 to July 2018.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England occurring between April 2018 and July 2018.

The service ensured staff could describe the types of incidents that may occur within the department and acted appropriately. Staff we spoke with knew how to recognise incidents when they occurred and reported them appropriately on the trust’s electronic incident reporting system.

Senior staff within the department reviewed, investigated and shared lessons learned from incidents with the whole team. Lessons learnt were shared with staff in a variety of methods; through staff handover, staff meetings and by email. Staff also told us they received a newsletter which detailed recent serious incidents and lessons learnt and would get individual feedback from the ward manager. The matrons would also do walk rounds asking staff about their understanding serious incidents and outcomes.

Staff understood the requirements of the duty of candour. Under the duty, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
When things went wrong, staff apologised and gave patients honest information and suitable support in line with the principles and requirements of the duty of candour. Our review of serious incident investigations showed that the duty of candour had been complied with.

The service had recently reviewed its major incident plan, which was available to staff on the intranet. Staff received major incident training during their induction with decontamination training repeated every two years.

Monthly mortality and morbidity meetings were mainly attended by clinicians but were an open forum for anyone to attend. These were also discussed in the directorate meetings if relevant. Minutes were disseminated to staff with improvements noted.

(Source: NHS Improvement – STEIS and trust data return DR186)

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the Heart of England NHS trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The service used best practice and national guidance well. The service used pathways that were evidence based in line with National Institute for Health and Care Excellence guidelines and the Royal College of Emergency Medicine’s clinical standards for emergency departments, for example paracetamol overdose.

Policies and procedures for the department were stored on the trust’s intranet and we saw that staff could access these quickly. The department participated in the national Royal College of Emergency Medicine audits so it could benchmark its practice against other emergency departments. The clinical lead consultant was responsible for updating the departmental guidelines.

Staff used Situation, Background, Assessment, Recommendation (SBAR); a technique that could be used to facilitate, prompt and appropriate communication especially amongst doctors and nurses. Other risk assessments included Waterlow pressure risk assessments, SAD and suicide assessment tools for patients with mental health needs. This was completed at regular intervals and staff fed back that they found this had improved patient care and safety.
**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 ensured that patients received food and drink when needed. There were several food and hot and cold drink dispensers within the entrance to the emergency department. In addition, there was a café serving hot and cold beverages and cakes.

We saw staff offer water and tea and coffee to patients and their relatives at regular intervals. Staff could also provide sandwiches for patients and relatives. We saw that baby food, snacks, juice and milk was available within the paediatric area.

**Emergency Department Survey 2016: Heart of England NHS Foundation Trust**

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts. We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

**Pain relief**

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

Staff gave patients pain relief when required. Pain relief including paracetamol, ibuprofen and codicodamol. Staff used Patient Group Directions (PGDs) to enable them to provide timely pain relief. The trust had a pain team who staff could contact if they needed advice. Staff told us that the team were responsive and would visit the department if required.

Patients we spoke with said they had been asked about their pain levels and felt that pain relief was provided in a timely manner.

The paediatric emergency department used a visual pain scale, that depicted ‘smiley face’ pictures. This provided an easy way for children to express the level of pain they were experiencing. Staff we spoke this said that the visual pain scale would also be used for adult patients who were non-verbal or did not speak English.

Where appropriate staff checked patient pain levels throughout patients stay in the emergency department and we noted this was also recorded in the nursing notes, along with any additional analgesia administered if necessary.

We saw evidence that analgesia was dispensed for children with moderate and severe pain within 20 minutes of arrival to the emergency department and pain score was reassessed and acted upon within 60 minutes. This was in line with the Royal College of Paediatrics and Child Health Standards for children in emergency care settings (standard 23).

**Emergency Department Survey 2016: Heart of England NHS Foundation Trust**

In the CQC Emergency Department Survey, the trust score for the question “How many minutes after you requested pain relief medication did it take before you got it?” was supressed.
The trust scored 7.8 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Patient outcomes

The service monitored the effectiveness of care and treatment.

At the time of inspection, the service lead for Royal College of Emergency Medicine (RCEM) was on leave and staff were unable to access the findings or describe any action plans resulting. However, staff were aware that action plans had been created because of the audits findings and we saw evidence of emails disseminating the information.

Data supplied by the trust following our inspection showed the trust had an action plan in place to address the RCEM paracetamol overdose standard. One action from the plan included the production of a proforma which provided comprehensive guidance for treatment. We saw evidence that this action had been reviewed in August 2018.

The trust reported that a new sepsis nurse had recently been appointed who would lead on audits and training. The trust was planning a re-launch of the sepsis pathway along with the NEWS2 introduction along with a plan to ensure updated paper charts, training packages and communication of these changes.

We included the audit data below from the acquired trust Heart of England NHS Trust as no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Good Hope Hospital emergency department failed to meet any of the national standards of 100%.

The department was in the upper UK quartile for four standards:

- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 44.4%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 93.0%; UK: 77%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
    - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 49.4%; UK: 19%.
    - Standard 5b (fundamental): within 4 hours (moderate). This department: 61.2%; UK:
The department was not in the lower UK quartile for any of the standards.

The department’s results for the remaining three standards were all within the middle 50% of results.

- Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 28.0%; UK: 19%.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 36.5%; UK: 26%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

  This department: 60.5%; UK: 52%.

**RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 Consultant sign-off audit, Good Hope Hospital emergency department failed to meet any of the national standards of 100%.

The department’s results for all four standards were all within the middle 50% of results:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 6.0%; England: 11%.

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0.0%; UK: 8%.

- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 6.0%; UK: 12%.

- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 5.2%; UK: 10%.

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 Severe sepsis and septic shock audit, Good Hope Hospital emergency department failed to meet any of the national standards of 100%.

The department was in the upper UK quartile for five standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 92.0%; UK: 69.1%.
• Standard 3: O₂ was initiated to maintain SaO₂ > 94% (unless there is a documented reason not to) within one hour of arrival. This department: 67.3%; UK: 30.4%.

• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 70.0%; UK: 43.2%.

• Standard 7: Antibiotics administered: Within one hour of arrival. This department: 62.0%; UK: 44.4%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 51.0%; UK: 18.4%.

The department was in the lower UK quartile for one standard:

• Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 46.0%; UK: 64.6%.

The department’s results for the remaining two standards were all within the middle 50% of results.

• Standard 4: Serum lactate measured within one hour of arrival. This department: 66.7%; UK: 60.0%.

• Standard 5: Blood cultures obtained within one hour of arrival. This department: 53.1%; UK: 44.9%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within seven days

Unplanned re-attendance rate within seven days - Heart of England NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

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 monitor the effectiveness of the service.

Staff received a robust corporate and local induction. Staff we spoke with said that their induction had been comprehensive and prepared them well for working in the trust. Staff also received a local induction and told us that this had prepared them well for working in the emergency department.

From April 2017 to March 2018, 88.8% of required staff within the emergency department at Good Hope Hospital received an appraisal compared to the trust target of 85%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>16</td>
<td>17</td>
<td>94.1%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>68</td>
<td>77</td>
<td>88.3%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>10</td>
<td>12</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

The service provided effective training and development. The service had a training and development lead. Each new starter would have a four-week supernumerary period followed by an 18–24 month development period. New starters would attend study days dedicated to each emergency department area followed by a three-month secondment into the area. Staff we spoke with told us of development pathways that had been created to help staff developed into more senior roles. These pathways consisted of several study days on various subjects such as cannulation, sepsis and dementia followed by on the job competency based training with regular appraisals. For those wishing to develop to a senior role the pathway would include management training. Additionally, the service had set up the fundamentals of emergency nursing practice which enable staff to complete their diploma and begin or top up their degree. Each band seven senior sister was responsible for ensuring their team had completed their training and as a result had set up a healthy competitive spirit to ensure their teams performed well.

Leaders ensured a good staffing skill mix. The service had four dual adult and paediatric trained consultants and employed nursing staff from varied backgrounds such as intensive care and burns. Leaders told us that they actively sought to recruit staff with varied background to ensure they met the needs of the population.

Senior sisters told us that they had protected management time which constituted 20% of their working hours. This time was protected and staff said they did not feel pushed to step back into clinical roles. Although, they would occasionally choose to do so if the managerial work had been completed.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
Staff ensured safe patient care by working positively together. Doctors, nurses and other healthcare professionals supported each other to provide good care. We observed effective multidisciplinary working between all groups of staff. Ambulance handovers were well communicated, caring, calm, and friendly. We observed positive interaction between emergency department staff and ambulance staff attending the department.

The team spoke positively about the trust’s frailty team and frailty consultants. The team would visit the department daily to aid patients’ mobility and condition management if they were frail, elderly, or required additional support to go home. The team would transport the patients to the trust’s medical day hospital therefore reducing the time spent in the emergency department.

Staff handovers were effective. We observed a nursing handover which detailed staff allocations including which area of responsibility they were working during that shift. Minimal patient information was provided during the handover we observed; however, a more detailed handover was discussed on the floor with staff in the majors area.

We also observed a medical shift handover meeting where each patient was discussed in detail; presenting conditions and symptoms, any tests undertaken or ordered, medicines prescribed for treatment. This also included relevant information such as interactions with other healthcare providers or safeguarding agencies. At this meeting we did not see evidence of any discussions concerning governance messages however, staff we spoke with said that such messages were discussed and they felt informed.

Seven-day services

Good Hope Hospital’s emergency department was available 24 hours a day, seven days a week. Staff could refer patients to an out of hours GP service, also based in the hospital, if that was the best pathway of care for them.

The service had access to a REACT team which included physiotherapist and occupational therapist support seven days a week. Access to diagnostic services was also readily available every day for example x-ray, magnetic resonance imaging (MRI), computerised tomography (CT) and pathology.

The service had three play specialists supporting them who worked onsite from 7am to 7.30pm seven days a week, 365 days a year.

The department’s flow coordinator worked three days a week but staff we spoke with said that a business case was being created to increase this to seven days.

Staff had access to CT, X-ray and pathology services seven days per week.

Health promotion

Staff supported national priorities to improve the population’s health for example, smoking cessation, alcohol dependency, dementia, and cancer. Patients’ accessed specific advice on health and condition management from a wide range of health-related leaflets and posters throughout the department.

We saw that staff gave advice to patients on discharge to enable them to manage their condition at home and specific advice on where to seek further advice if necessary.

The patient electronic record system enabled staff to identify patients who may require additional support. For example, alerts were available to identify patients who had a learning disability or
dementia. Staff could also refer patients to external agencies or organisations for additional further support.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust procedures when a patient could not give consent.

Although not all staff were not aware of the Mental Capacity Act, we observed staff taking consent appropriately. Staff received mental capacity act training as part of the safeguarding adults and children level 2 module. We saw staff take consent through verbal and implied consent. Although on review of the records we were not able to find consistent recording of consent to treatment in patient records despite being aware of a cognitive assessment tool for staff to use. We saw that where a patient potentially lacked capacity, nursing staff escalated this to the medical team to carry out a formal assessment of the patient’s capacity.

Paediatric staff we spoke with knew how to apply the Gillick competency when supporting children and young people. Gillick competency determines that children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. If a child does not pass the Gillick test, staff must get the consent of a person with parental responsibility or sometimes the courts prior to commencing treatment.

Some staff we spoke with, including security and ward clerks, said they could access adolescent mental health training. Children attending the emergency department would be seen in the paediatric department and if medically fit would be discharged to the children’s assessment unit with a referral to the local child and adolescent mental health service (CAMHS). If they were not medically fit they would be transferred to a local paediatric inpatient ward and again referred to the CAMHS.

The service had a clear mental health pathway. Staff would contact the local Rapid Assessment Interface and Discharge (RAID) team, who would attend within an hour and could support patients with psychiatric liaison and assessments. Staff would also raise a safeguarding concern to ensure that the local authority could support the patient with dedicated mental health care. While the service did not have a specific mental health team staff would use an enhanced care observation booklet, which was good practice. This booklet prompted staff to take a higher level of patient detail, such as description in case the patient absconded, and included a SAD PERSONAS score; an acronym based on 10 suicide risk factors and is used to assess the likelihood of a suicide attempt. However, the service would also use their security team to observe patients as a standard. This was not good practice and should only be considered if the patient became violent or was a potential absconder.

Nursing staff did not have a clear understanding of the deprivation of liberty safeguards. Staff we spoke with said they had not received any deprivation of liberties training and did not have an awareness of the types of actions that could be restraint; for example, placing a walking frame out of reach of a patient or placing a tray table in front of a chair or over a bed to prevent a patient from getting out of bed. This was a risk as the service regularly provided extended periods of care for patients.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patient feedback showed less people would recommend the service compared to the national average. Good Hope Hospital’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from September 2017 to August 2018. Note data taken pre-April 2018 was only provided for contextual purposes and it did not form part of our judgement.

Staff discussed friends and family feedback in their handovers and we saw this evidenced in folders which contained both positive and negative feedback. We saw trust friends and family boards displayed on the walls in the waiting area which were well stocked with comment cards. However, the trust had not completed the you said, we did section which highlighted how they had responded to feedback. Staff in the paediatric emergency department used child friendly comment cards which asked children to pick a smiley or non-smiley face that best described how they felt about the service.

In the CQC Inpatient Survey 2017, Heart of England NHS Foundation scored about the same as other trusts for the question “were you given enough privacy when being examined or treated in the A&E department?”. We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Staff cared for patients and their families. Patient’s and relatives fed back that staff had treated them well with compassion and kindness. We saw nursing and medical staff treat patients and their relatives in a respectful way and ensured that privacy and dignity were maintained. We saw cubicle curtains were drawn and doors were closed as appropriate. Staff took time to speak to patients who might be frightened or confused, treating them sensitively and with respect. We saw thank you cards that thanked staff for their “knowledge and team work” and “kind, gentle and
supportive manner. Staff we spoke with said they had received biscuits, specialist coffee and in
one instance a monetary donation.

Staff understood the needs of patients with conditions and need. Staff displayed non-judgemental
behaviour to patients such as those living with a form of dementia or mental health illness
However, staff told us that if a patient presented with mental health concerns they would contact
security regardless of whether the patient was violent or a flight risk which was not good practice.

(Source: NHS England Friends and Family Test and Care Quality Commission Inpatient Survey
2017)

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff understood the impact that a person’s care, treatment or condition would have on their wellbeing
and on those close to them, both emotionally and socially. Staff checked on patients to ensure their
needs were met. This was in line with National Institute for Health and Care Excellence Quality
Statement QS15 Statement 10: Patients have their physical and psychological needs regularly
assessed and addressed, including nutrition, hydration, pain relief, personal hygiene, and anxiety.
Staff would encourage patients and their relatives to use one of the quiet rooms if a patient became
distressed in the open environment. We saw staff treat those patients with privacy and dignity only
entering the room when medically required or requested by the patient. However, staff we spoke with
expressed concerns that the increasingly high demand on their service meant that the opportunity to
provide high quality hands on care was reducing.

Staff ensured that patients with mental health or dementia diagnoses received advice about their
condition. Patients with mental health needs were treated within a designated side-room near to
the nurses’ station and monitored by CCTV. Staff referred patients appropriately to the local Rapid
Assessment Interface and Discharge (RAID) team.

The service ensured that patients and their families had their religious and spiritual needs met.
The chaplaincy service was available 24 hours a day, seven days a week and could accommodate
requests for support from all religious denominations. There was a designated chapel and prayer
room within the hospital that was open 24 hours a day, seven days a week, where people could
pray, meditate, and leave messages. The chaplaincy service acted as liaison between the patient
and their faith community as a means of providing the spiritual and pastoral care needed.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients scored the trust similar to the national average. The trust scored about the same as
other trusts for 23 of the 24 Emergency Department Survey questions relevant to the caring
domain. The score for the remaining question was suppressed due to low figures. We included
this data item from the acquired Heart of England NHS Foundation Trust where no more recent
data was available. We only provided this for contextual purposes and it did not form part of our
judgement.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>No score</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>back to work or drive a car?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

In the CQC Inpatient Survey 2017, Heart of England NHS Foundation scored about the same as other trusts for the question “while you were in the A&E department, how much information about your condition or treatment was given to you?”. We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Staff communicated with people so that they understood their care, treatment and condition and any advice given. We saw staff talk to patients in plain English, taking the time to explain their treatment options. Patients, families and carers we spoke with said they felt involved in the decisions. Emergency department staff and RAID staff would telephone patients and their families to follow up with them. However, one patient told us that when they had been moved into the corridor no one had spoken to them for two hours and they had not been included in the decision to move them to the acute medical unit.

Staff responded positively to patient feedback. Staff gave an example when feedback had stated that patient’s privacy and dignity were not always protected at handover. In response staff had moved their on the floor feedback to the centre of the room, furthest away from earshot and protected by furniture. They had also ordered a number of privacy and dignity boards which they were awaiting delivery on.

(Source: Emergency Department Survey October 2016 to March 2017; published October 2017 and Care Quality Commission Inpatient Survey 2017)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people.

Services provided reflected the needs of the population served. Good Hope Hospital primarily served Sutton Coldfield, an area with a high percentage of people aged 65 or over. The service had access to a frailty team who would attend the department to do assessments and wherever possible would transfer the patient to the medical day hospital. The frailty team were available Monday to Friday from 8am to 5pm and consisted of a team of consultants, physiotherapists and occupational therapists who provided dedicated patient support to avoid admitting them to hospital.
Additionally, the service had a REACT team consisting of physiotherapists and occupational therapists who were available seven days a week who would attend the department to do assessments.

The trust had decorated the paediatric emergency department with children in mind. The area contained a range of appropriate toys for children, TV, and age appropriate books.

There was adequate seating and space in reception and the minors’ waiting area. Although we did not see any visitors to the service standing the paediatric and majors’ waiting areas were less spacious. The reception areas were well equipped to provide food and had a computer screen showing all local bus services and their times.

The service competently streamed appropriate patients to a primary care service. The emergency department had an on-site GP who worked Monday to Wednesday and, an out of hours GP service (BADGER). These services managed patients who attended the emergency department but were more appropriate to be seen by a doctor.

**Meeting people’s individual needs**

**The service took account of patients’ individual needs.**

**Emergency Department Survey 2016 - Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust scored better than other trusts for one of the three Emergency Department Survey questions relevant to the responsive domain. The trust scored about the same as other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.5</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

The service made reasonable adjustments for patients. Staff had access to interpretation services for patients and families whose first language was not English and told us that they could scan letters to produce them in a different language. However, they could not provide leaflets in alternative languages. This posed a risk to patients.

Staff made reasonable adjustments so that people with a disability could access and use services on an equal basis to others. Waiting rooms had sufficient space for patients in wheelchairs to manoeuvre with ease. The service had memory boxes for patients living with dementia which contained jigsaws and other activities for the patient. The service was also looking at implementing symbols on the department that would indicate a patient living with dementia.

A chapel and prayer room was available and the trust provided a chaplaincy team for patients, relatives and staff of all faiths, or none. Patients had access to leaflets in the waiting area providing information on a variety of health conditions.

We saw paediatric nurses and play specialists used distraction techniques when supporting children and had a wide range of equipment, for example toys, and TV to support patients and
help to keep them calm. We observed a paediatric nurse using bubbles to distract a toddler. Then play specialist would also escort children to x-ray and the plaster room if they required further soothing and distraction. The department also provided facilities for older children such as DVDs and games for older children. However, there was no on site WIFI for children to access the internet.

Although there was no dedicated sensory room we saw sensory equipment was available in the paediatric emergency department. Staff were aware of learning disabilities and other health conditions which might require some adjustments to be made to accommodate patients’ individual needs. Patient and parent information was provided in child friendly ways, including pictorial depictions of the pain scale to encourage children to meaningfully engage with care staff.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow

Although people could access the service when they needed it, waiting times to admit, treat and discharge patients were not in line with the national average.

Although the service performed worse than the national average, it ensured patient flow was managed well by implementing a dedicated ambulance handover process. This process gave clear responsibilities to staff to follow. The service worked with the local ambulance service and had a dedicated hospital ambulance liaison officer (HALO) onsite. The HALO coordinated patient flow between the two services and where necessary would assist the nursing staff by taking responsibility for patient handover from the ambulance crew. This allowed ambulance crews to discharge their responsibility to the patient to return to active duty and respond to other calls.

The service assigned nursing staff as responsible for accepting and detailing the ambulance handover and these were highlighted by wearing orange arm bands. We saw a handover take place in a confidential manner, maintaining the patient privacy. The handover was short and effective and a pre-designed proforma was completed detailing all the salient information.

Once the patient had been handed over from the ambulance crew they were then taken to one of three assessment cubicles for a rapid assessment. This would be completed by an advanced care practitioner or senior doctor worked alongside two nurses and comprised of a full physical assessment and a computer generated structured assessment including essential information such as pain scores. The staff would then assess the patient suitability to be transferred to a chair or trolley to await treatment.

The hospital had an admission avoidance provision in place which consisted of a GP located within the emergency department, an onsite out of hours GP service known as BADGER and a medically led ambulatory emergency care centre (AEC). There was a hospital wide escalation policy for when the emergency department becomes crowded with locally agreed triggers. The on-site clinical site manager would make regular visits to the department to understand their capacity and patient flow and would ultimately decide as to whether to open additional beds within ward 22 or the discharge lounge. Staff we spoke with said they felt supported and empowered to make the decision.

Staff worked effectively across the hospital to manage patient flow. Staff felt that there was a
hospital approach to managing demand and capacity within the emergency department. The service faced challenges from a lack of available beds for patients waiting to be admitted and a lack of available mental-health inpatient beds in the area, which meant that patients were waiting longer in the department. Staff also expressed that patient safety was paramount and, despite the challenges faced, patients would not be signed off by consultants for discharge from the department until their safety was assured. The local area had an aging population and staff felt that often delays were due to patients having multiple medical issues that required them to have a social package in place before they could be discharged.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour.

From October 2017 to September 2018 Good Hope Hospital failed to meet the standard and performed worse than the England average. Data for October 2017 to March 2018 was provided for contextual purposes and it did not form part of our judgement. Note the England average figures for September 2018 had not been published at the time this report was written.

![Median time from arrival to treatment (all patients)](image)

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

From October 2017 to September 2018 Good Hope Hospital failed to meet the standard and performed worse than the England average. Data for October 2017 to March 2018 was provided for contextual purposes and it did not form part of our judgement.
Percentage of patients waiting more than four hours from the decision to admit until being admitted

From October 2017 to September 2018 Good Hope Hospital performed worse than the England average. Data for October 2017 to March 2018 was provided for contextual purposes and it did not form part of our judgement.

Number of patients waiting more than 12 hours from the decision to admit until being admitted

From October 2017 to September 2018, two patients waited more than 12 hours from the decision to admit until being admitted. These occurred in February and May 2018.

Median total time in A&E per patient (all patients)
From October 2017 to September 2018 Good Hope Hospital performed worse than the England average. Data for October 2017 to March 2018 was provided for contextual purposes and it did not form part of our judgement.

![Median total time in A&E per patient (all patients)](chart)


**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

**Summary of complaints**

From April 2017 to March 2018 there were 17 complaints about urgent and emergency care services at Good Hope Hospital. The trust took an average of 32 working days to investigate and close complaints. This is not in line with their complaints policy, which stated complaints should be resolved within 30 working days. One complaint was still open at the time of reporting and had been open for 85 days. The main theme was all aspects of clinical treatment with 11 complaints.

Leaders ensured staff were aware when complaints were received and worked with staff to ensure lessons were learned. We reviewed four sets of staff meeting minutes and saw that complaints were discussed and discussions included common themes, lessons learned and outcomes. Staff we spoke with said that senior sisters would talk to them about complaints and were open to feedback on lessons learned and ways to improve. We saw a complaints and compliments folder in the staff room which gave staff opportunity to read complaints and compliments received within their break and ensured that all staff had an opportunity to make themselves aware. We also saw that complaints were discussed during nursing handover. Most patients and relatives we spoke to told us they would know how to make a complaint, and were aware of Patient Advice and Liaison Service.
Leaders gave examples of where they had contacted complainants by telephone preferring to discuss complaints directly rather than by letter. Examples were given where patients had been invited back to the department to see changes made as a result of their complaint.

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 17 compliments for Good Hope Hospital urgent and emergency care.

*(Source: Routine Provider Information Request)*

**Is the service well-led?**

**Leadership**

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Leaders understood some challenges facing the service. The departmental and divisional leaders described the current challenges which included staffing levels and overcrowding. Leaders could clearly describe the actions that had already been taken, or were planned, to meet these challenges. The leaders for the department were motivated to improve the service provided by the department and worked closely across the different sites. Leaders we spoke with said they felt listened to and represented at board level.

Local leaders were visible and supportive to their staff. All staff we spoke with said that both the matron and the consultant team were visible and accessible. Staff they felt supported in their role and their development.

Leaders developed staff and implemented succession planning effectively. The matron had developed the band seven senior sisters so each was responsible for an area of development such as staffing, sepsis or performance and had responsibility for a team of junior staff. Additionally, each senior sister had been trained to deputise for the matron when they were off site. The service’s training and development lead had introduced a development pathway for band five staff which prepared them for a future career as a band six. Band six nurses also had a development pathway like that of the band five but with the addition of management training to aid development into a band seven role.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The service had a clear vision and a set of values embodied by their staff. The emergency department teams at Good Hope Hospital, Heartlands Hospital and Solihull Hospital (HGS) had a shared vision and values. Their vision was to aspire to excellence and reflect, learn, improve and innovate. The values were collaborative, honest, accountable, innovative and respectful. Staff knew and understood the vision and values and their role in achieving them. We saw staff embody them through their interactions and attitude. The new trust vision and strategy was not yet fully integrated into the service. Most staff we spoke with could not say what these were when asked.
The new strategy had not yet been integrated into the service. Since the recent acquisition of the Heart of England NHS Foundation Trust the trust had produced a renewed vision ‘to build healthier lives and was implementing a new strategy to support this. Post inspection, the trust submitted their emergency department strategy for 2018-20 and on review we saw that this referred to the Queen Elizabeth Hospital with mention of integrating the HGS sites but was not yet specific to HGS. We saw that the strategy had strategic priorities that were aligned to the wider health and social care economy, and that services were planned to meet the needs of the relevant population. However, this had yet to be fully integrated into HGS.

Leaders told us that they felt the trust had a clear strategy for the emergency department and felt that their views were being included. They worked with the Birmingham and Solihull Sustainability and Transformation Partnership. This enabled partnerships with the wider health and care system and with other public services and commissioners to promote health and wellbeing.

(Source: Trust data return DR185)

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service had a supportive culture where staff felt respected and valued. Staff we spoke with said they felt the service had an open culture with shared ownership of developing the service. All staff said they felt part of the family. Leaders were proud of their staff and spoke of how they worked tirelessly as a group to improve and support one another. Staff were supported to report incidents and feedback to individuals was provided in a positive way. Staff told us they felt proud to work at Good Hope Hospital.

Both medical and nursing staff spoke highly of each other and staff felt comfortable to both offer and receive advice and support. Staff told us that consultants were always available whether onsite or over the telephone to provide advice and guidance over the telephone. We spoke with ambulance staff from the local NHS ambulance trust, they told us that staff were approachable and patient focused and they felt part of the team.

There was a good emphasis on the safety and well-being of staff. Staff told us that shift patterns had been revised to become more flexible to individual needs. The service had a security team that would make frequent visits to the department and would attend if requested. However, security staff we spoke with expressed concerns that they could not provide 24-hour support.

The culture centred on the needs and experience of people who use services. We saw staff work together to meet the needs of their patients. We saw patient and relatives comfort needs being addressed such as food and drink. Staff spoke about a hospital wide approach to treating patients and felt that overall every team worked together.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Staff were clear about their roles within the structure, what they were accountable for, and to whom. The service had a senior sister who acted as the sepsis lead and who oversaw the
departmental sepsis management. Staff told us and we saw clinical messages were discussed at handover and best practice was shared such as sepsis management.

There were monthly emergency department meetings which were attended by senior staff who then disseminated the outcomes to the band seven senior sisters, who in turn disseminated to the junior staff. We also saw a communication book was kept in the staff room which detailed meeting outcomes and key messages.

We reviewed the minutes of the last three emergency clinical governance meeting minutes and saw evidence that performance, safety risks and learning from incidents and complaints were discussed and shared at the meeting.

The mortality and morbidity meetings reviewed deaths in the department. The meeting was open to a wide range of multidisciplinary team staff, including senior and middle-grade medics, nursing staff and other disciplines. Feedback and direct actions from reviews including learning were shared through handovers and emails.

(Source: Trust return DR183, DR184)

Management of risk, issues and performance

Leaders identified risks and planned to eliminate or reduce them, and coped with both the expected and unexpected.

Leaders could describe the risks and issues affecting the service. All leaders we spoke with knew the risks identified on the risk register, however, few front-line staff knew what was on the risk register or where it was located. We saw handovers were focused on patient safety, ensuring staff knew about the need to complete safety checklists, documentation, and monitoring patients. We were not assured department leaders had sufficient oversight of all risks within the department, for example poor access and flow, consultant hours not meeting RCEM standards and poor staff knowledge around DOLS.

As part of the routine provider information return we requested a copy of the service risk register but received a copy of the corporate risk register. Post the inspection we re-requested the service risk register and the trust submitted their risk profile for October 2018. The risk profile identified five items specific to the either Good Hope emergency department or trust wide emergency care. However, the risk profile did not provide any actions or control measures not did it provide a date when the risk had been reviewed.

<table>
<thead>
<tr>
<th>Risk Title</th>
<th>Site</th>
<th>Current score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient number and skill mix of junior and middle grade staff: Impact upon quality and safety of care</td>
<td>Trust Wide</td>
<td>20</td>
</tr>
<tr>
<td>A&amp;E ED Overcrowding and Impact of extended stay in ED</td>
<td>Trust Wide</td>
<td>20</td>
</tr>
<tr>
<td>Unacceptable delays for assessment and admission to mental health beds, of high risk patients with Mental Health emergencies * score under review by specialty / division</td>
<td>Trust Wide</td>
<td>15</td>
</tr>
<tr>
<td>Delivery of quality and safe care due to Nursing vacancy *score under review</td>
<td>Good Hope</td>
<td>12</td>
</tr>
<tr>
<td>Age of PC's in ED</td>
<td>Good Hope</td>
<td>4</td>
</tr>
</tbody>
</table>
We reviewed three sets of emergency department clinical governance meeting minutes and saw that risks were discussed. The discussions related to the service risk register, which we did not see sight of, and the minutes documented changes to scoring, updates and actions. Risks included staff vacancies, security issues and included the five risks detailed above.

Although not evident on the risk profile, on inspection the shortage of consultants and the reduced consultant roster was raised as a risk. We saw that this risk was evidenced in the governance minutes.

The service planned for emergencies and staff understood their roles if one should happen. The hospital had a major incident plan and staff were aware of where the plan could be accessed.

The service had training and support mechanisms in place for the recognition and management of sepsis. We saw sepsis six was referred to in multiple proformas and all staff we spoke with knew how to recognise and manage patients presenting with sepsis. This was in line with the National Institute for Health and Care Excellence Guideline NG51 Sepsis: recognition, diagnosis and early management. The Sepsis Six aimed to implement three diagnostic and three therapeutic actions within one hour of a diagnosis of potential sepsis. These included monitoring of oxygen levels, fluids and urine output, measurement of lactate levels and the commencement of blood culture tests and antibiotics.

(Source: Trust data return DR183, DR187)

**Information management**

The trust did not have a robust process to collect, analyse, manage and use information well to support all its activities. However, service leaders had a good understanding of local service performance.

Leaders had a good understanding of performance. They demonstrated a good understanding of performance across the department and gave examples of how performance was used to drive improvements across the service. Staff had access to information they needed to carry out their roles effectively with policies and procedures available on the trust’s intranet.

Performance information was collected this included the collection of data to support national audits and surveys including those by the Royal College of Emergency Medicine, the Safety Thermometer, the NHS Friends and Family Test, and interactions with the ambulance service. However, staff were not always aware of why this information was gathered and were not always aware of any results gathered from this.

The trust did not always have oversight of site specific performance. Post inspection we submitted several data requests and found the data quality to be mixed and not always site specific.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Leaders engaged well with the local community and staff to improve the service. Leaders we spoke with had attended external meetings with local community groups and patient focus groups. An example was given of nursing homes encouraging the department to utilise the ‘this is me’ passport and as such work was being undertaken to implement its use. They told us that when
they recruited staff to the department they did so with the community in mind to ensure that the skill mix met the needs of the population.

Leaders did not have direct contact with their local clinical commissioning group but felt they were well represented by their senior leadership team. They also felt the out of hours GP service and GP in emergency department service helped strengthen links to the community.

Staff we spoke with said they felt engaged with the leaders particularly the matron within the department. They told us that matron regularly visited the department and they felt comfortable to approach matron with any concerns. However, staff said they did not see the senior leadership team. Staff could also feed into a local forum known as Risky Business at which they could discuss areas of concern such as workload, teaching and get oversight of trust wide concern. After the forum a written update was then circulated via email.

The trust held quarterly emergency department meetings at Heartlands Hospital and all staff from urgent and emergency services were invited. Although we were told that many staff from Good Hope Hospital did not get the opportunity to attend these meetings, messages would be communicated back to staff via email and handover.

(Source: Trust data return DR97)

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The band seven sisters and matron ensured staff development was effective. The team had implemented an induction programme which ensured that new starters to the department would initially have a four-week supernumerary period after which they would attend a study day followed by a three-month secondment for each area. This ensured that all new starters had time to acclimatise to working with the emergency department environment and were confident in each area.

Staff we spoke with said there was a culture of supportive learning, improvement and development embedded in the department but that the workload did not always enable this to happen as quickly as liked.

The service improved their staffing to provide effective mitigation to meet local demand. The service acknowledged that demand often exceeded their capacity and introduced a role dedicated to looking after patients who were waiting in the corridor. The matron at Good Hope Hospital had been invited to share this best practice at the trust’s other emergency departments with a view to them adopting it as well. Additionally, the matron had shared best practice learning that resulted from their emergency nurse practitioner led minors’ unit and again this practice was being explored at the other sites.
University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust underwent a merger by acquisition in April 2018, therefore all national datasets contained within this appendix relate to this period onwards.

The medical care service at University Hospital Birmingham NHS Foundation Trust provides care and treatment for a wide range of specialties including:

- cardiology
- colorectal
- diabetes
- endoscopy
- infectious diseases
- neurology
- oncology
- renal
- respiratory
- stroke

There are 1,579 medical inpatient beds located across 56 wards plus 17 beds on a multi-specialty ward for private patients at Queen Elizabeth hospital.

The trust also provides acute medical care at Birmingham Chest Clinic, Castle Vale Renal Dialysis Centre and Runcorn Road Renal Dialysis Centre.

(Source: Routine Provider Information Request (RPIR) – Sites – All tab)

At Queen Elizabeth Hospital acute medicine is delivered through a 74-bedded consultant-led clinical decision unit which accepts referrals from the emergency department and the single point of access unit. The unit has a four-bedded level two facility catering for patients with multiple organ failure. The ambulatory medical clinic is open 24 hours a day, seven days a week and manages approximately 7,000 patients per year.

(Source: Acute Provider Information Request (RPIR) – Context acute QE tab)

Specialist elderly care services operate across the Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital sites with a frailty ambulatory emergency care available on the medical day units (MDU) at both Birmingham Heartlands Hospital and Good Hope Hospital. Teams are multi-professional and assess patients in the emergency department who are suitable to be managed in the MDU as an ambulatory patient. The team also carry out comprehensive geriatric assessments, instigate and carry out appropriate diagnostics and interventions with the aim to return the patient to their usual place of residence with or without support services. At Solihull Hospital ambulatory care is provided via the frailty advice and support team who operate out of the medical day unit.

Additionally, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital provide ortho-geriatric support to the trauma and orthopaedic wards and all geriatricians run afternoon outpatient clinics.

There is also a well-established dementia and delirium team which works across all of the
complex elderly care wards at all three sites and aims to educate staff, patients and carers on dementia and delirium care.

(Source: Acute Provider Information Request (RPIR) – Context acute HGS tab)

A site breakdown can be found below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital Birmingham</td>
<td>Bournville ward</td>
<td>Older adults</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Coronary care unit</td>
<td>Cardiology</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Harborne ward</td>
<td>Older adults</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Ward 302</td>
<td>Renal</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Ward 303</td>
<td>Renal</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 304</td>
<td>Cardiology</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 411</td>
<td>Neurology</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 513</td>
<td>Diabetes</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 514</td>
<td>Stroke</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 515</td>
<td>Respiratory</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 516</td>
<td>Respiratory</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 517</td>
<td>Multispecialty</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Ward 518</td>
<td>Multispecialty</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 622</td>
<td>Oncology</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Ward 623</td>
<td>Oncology</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Ward 625</td>
<td>Haematology</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Ward 726</td>
<td>Liver</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 727</td>
<td>Liver</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward 728</td>
<td>Colorectal</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>Ward West 1</td>
<td>Older adults</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Ward West 2</td>
<td>Older adults</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td><strong>Total beds</strong></td>
<td></td>
<td><strong>653</strong></td>
</tr>
</tbody>
</table>

| Birmingham Heartlands Hospital | Rowan ward         | Gastroenterology         | 25   |
|                                | Ward 2             | General medicine         | 34   |
|                                | Ward 3             | Renal                    | 34   |
|                                | Ward 6             | Cardiology               | 36   |
|                                | Ward 7             | Short stay acute medicine| 20   |
|                                | Ward 19            | Oncology                 | 19   |
|                                | Ward 20 acute medical unit 1 | -         | 46   |
|                                | Ward 21            | Elderly care             | 27   |
|                                | Ward 22 acute medical unit 2   | -      | 26   |
|                                | Ward 23 acute stroke unit      | Stroke      | 14   |
|                                | Ward 23 HASU       | Stroke                   | 16   |
|                                | Ward 24            | Respiratory              | 43   |
|                                | Ward 26            | Cystic fibrosis unit     | 20   |
|                                | Ward 28            | Infectious diseases and tropical medicine | 46   |
|                                | Ward 29            | Diabetes                 | 28   |
|                                | Ward 30            | Elderly care             | 28   |
|                                | **Total beds**     |                          | **462** |
|                                | Acute medical unit assessment | -    | 34   |
The medical wards at Good Hope Hospital include the following; assessment medical unit, assessment short stay unit, short stay acute medical unit, diabetes/gastroenterology, respiratory, elderly care, frailty unit, cardiology and stroke. These were all provided at one location. Good Hope Hospital serves all patient groups including elderly people and children and young people. There are 309 beds across 11 wards. Services are provided 24 hours a day, seven days a week.

(Source: Routine Provider Information Request (RPIR) – Sites – All tab)
Is the service safe?

Mandatory training

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

Good Hope Hospital

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>280</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>279</td>
</tr>
<tr>
<td>Medicines management</td>
<td>278</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>277</td>
</tr>
<tr>
<td>Waste management</td>
<td>273</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>263</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>264</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>257</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>238</td>
</tr>
<tr>
<td>Information governance</td>
<td>236</td>
</tr>
<tr>
<td>Fire safety</td>
<td>232</td>
</tr>
<tr>
<td>Resuscitation – clinical</td>
<td>229</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall training compliance rate of 92.6% for qualified nursing staff. The trust’s 90% completion target was met for eight of the 12 mandatory training modules for which qualified nursing staff were eligible. The resuscitation - clinical module had the lowest completion rate, at 82.1%.

Nursing staff mostly received the appropriate mandatory training. The nursing staff met the mandatory training target for 66.7% of mandatory training modules. None of the training levels fell below 82.1%.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in medicine at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Manual handling – load handling</td>
<td>1</td>
</tr>
</tbody>
</table>
In medicine, the hospital had an overall training compliance rate of 79.5% for medical staff. The trust’s 90% completion target was met for six of the thirteen mandatory training modules for which medical staff were eligible. The waste management module had the lowest completion rate, at 52.0%.

Medical staff had not met the trust target for mandatory training. Medical staff mandatory training levels fell below 80% in 46.2% of modules and below 70% in 30.1% of modules. This was far below the trust target of 90%.

Clinical resuscitation training levels were low for both staff groups. Both Nursing staff (82.1%) and medical staff (71.2%) fell below the mandatory training target level (90%) for clinical resuscitation. This presented a risk to patients if staff who were not appropriately trained were undertaking resuscitation.

Mandatory training was of a good standard and staff were reminded when they were due for mandatory training. All staff we spoke with told us they got regular updates when they needed to complete mandatory training, through email centrally and from their managers on the wards.

Staff mostly had the time to carry out the mandatory training they needed to. Most staff we spoke with told us they had time to carry out the training they needed to. One staff member reported that they sometimes did training at home as they did not always have time on the wards. Some staff reported that sometimes there were issues trying to get people booked onto mandatory training when sessions were already full.

**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.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>74</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>71</td>
</tr>
<tr>
<td>Medicines management</td>
<td>70</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>70</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>70</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>64</td>
</tr>
<tr>
<td>Fire safety</td>
<td>58</td>
</tr>
<tr>
<td>Resuscitation – clinical</td>
<td>52</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>49</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>48</td>
</tr>
<tr>
<td>Information governance</td>
<td>47</td>
</tr>
<tr>
<td>Waste management</td>
<td>39</td>
</tr>
</tbody>
</table>
In medicine, the hospital had an overall safeguarding training compliance rate of 99.5% for qualified nursing staff. The trust’s 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in medicine at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>71</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>61</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall safeguarding training compliance rate of 89.2% for medical staff. The trust’s 90% completion target was met for one of the two safeguarding training modules for which medical staff were eligible.

Staff mostly had the appropriate safeguarding training to carry out their roles. Nursing staff met all mandatory training targets and medical staff met one out of two mandatory training targets, none of the mandatory training levels fell below 83.6%.

There were systems and processes in place to keep people safe. We were told by staff that they were informed when at risk patients were to be moved onto their wards from other areas of the hospital.

Staff mostly had a good understanding of safeguarding. Most staff we spoke with had a good understanding of safeguarding and knew what they should do if they identified any potential signs of safeguarding abuse. However, some staff members said they would tell the ward manager and could not say anything further about the process. There was an information board on ward 21 with regards to safeguarding vulnerable elderly people from abuse, which highlighted the signs to look out for.

**Cleanliness, infection control and hygiene**

**Systems in place to prevent and protect people from a healthcare-associated infection were not always followed by staff.**

Wards were mostly clean and well maintained, however we were not sure how the trust was assured by this. The wards were mostly observed to be clean and tidy. Most pieces of equipment on the wards were noted to have ‘I am clean’ stickers clearly visible, signed and dated. However, on ward 9 there was a soiled commode and no ‘I am clean’ sticker. There were also open soiled
bags on the ward floor in the Medical Assessment unit. Cleaning schedules were seen on some wards. Following our inspection we requested cleaning records for all wards. We received one weeks completed schedule for one ward with no log of dates or signatures.

The wards had hand sanitiser throughout. Hand sanitiser was available at the entrance to every ward and throughout the wards. Staff encouraged patients and the public to wash their hands.

Patients were not always kept safe from the risk of a healthcare-associated infection. Side rooms were available to isolate patients with a suspected or confirmed infection. Care plans were used for these patients which enabled staff to take extra precautions and help prevent the spread of infection, which included keeping the doors closed. There were two occasions, one on ward 10 and one on the Medical Assessment unit, when doors that should have been closed due to a patient needing to be isolated were left open. On both of these occasions the doors were closed immediately when it was raised with staff. On ward 11, in two of the bays, catheters were observed to be touching the floor.

Staff did not always follow best practice guidance around infection prevention and control. For most of our inspection we observed staff bare below the elbows and most were following hand hygiene guidance. However, we carried out two observational hand hygiene checks on two of the wards. On the Medical Assessment unit we observed staff wash their hands on 14.2% of the occasions where they had the opportunity to do so and should have done. On ward 7 we observed it to be 45.5%. There was also one occasion on ward 11 where a Doctor was observed to be not bare below the elbows.

Environment and equipment

The service did not always have suitable premises to keep patients safe.

Not all wards were designed in a way which kept people safe. On wards 9 and 11, the windows were observed to open more than 100mm which is not in line with Health and Safety Executive (HSE) guidance. This was escalated to the trust executive team immediately. We returned to these wards one week later, our concerns had not been addressed. Most other wards were designed in a way which kept patients safe from avoidable harm.

Store rooms were not always secure in a way which protected patients from avoidable harm. Store rooms and other rooms which should have be kept secure were generally secure with code access and were only left off the latch when in use. However, on wards 9 and 11 COSHH products (Control of Substances Hazardous to Health) were not stored securely. This was escalated to the trust executive team immediately. We returned to these wards one week later. COSHH products on ward 9 were stored in a locked cupboard however, storage had not been addressed on ward 11. During a night visit to ward 10 we observed the kitchen door to be open. This presented as a fire hazard. In addition, the room could have been accessed by a vulnerable patient.

Waste was not always managed appropriately at the hospital. On wards 8,10 and 24 a total of seven sharps bins were overfilled. An overfilled sharps bin could cause a needlestick injury. Needlestick injuries are wounds caused by needles that accidentally puncture the skin. Needlestick injuries are a hazard for people who work with hypodermic syringes and other needle equipment.

Resuscitation trolleys were mostly in good order. However, checks, to ensure equipment was safe and ready to use in an emergency, had not always been carried out. Resuscitation equipment, including emergency medicines, was readily available on all wards we visited. Most observed resuscitation trolleys were in good order and equipment was up to date and most drugs boxes were sealed. However, on ward 7 the seal around one of the drugs boxes was torn. Checks on
Resuscitation trolleys were inconsistent. On three out of eight wards where resuscitation trolleys were checked some dates were missed. On the Medical Assessment unit there were three days from 14 July 2018 to the date of inspection where it had not been checked. On ward 8 there were nine days from 14 July 2018 to the date of inspection where it had not been checked. On ward 10 there were 20 days from 12 July 2018 to the date of inspection where it had not been checked.

Electrical equipment was maintained to a good standard. All items had been serviced and we saw visible safety tested stickers indicating a service due date of October 2018.

Staff had the equipment to manage pressure ulcers well. Staff had access to pressure relieving equipment and managed pressure ulcers well. Grade two pressure ulcers had reduced and there had been no grade three pressure ulcers from April 2018 to September 2018.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Staff completed risk assessments for each patient. Comprehensive risk assessments were carried out, kept up to date, visible and in line with national guidance in all care records that were observed. Staff assessed the nutritional and hydration needs of patients along with the patient’s risk of pressure damage and falls. Staff used the Situation, Background, Assessment, Recommendation (SBAR) communication tool in order to handover patients from other departments. SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

Staff monitored patients effectively to ensure they were safe from sepsis. A Modified Early Warning System (MEWS) was used for patients to assist staff in the early recognition of a deteriorating patient. MEWS is a guide used by medical services to quickly determine the degree of illness of a patient. Staff recorded routine physiological observations such as blood pressure, temperature, and heart rate to assess whether a patient’s condition was deteriorating. We saw MEWS documentation was completed appropriately which meant that patients were being monitored for signs of deterioration and could be treated in a timely way. Patients with suspected and/or confirmed sepsis were continually assessed and monitored using the MEWS. Where the sepsis pathway had triggered we observed the sepsis paperwork to have been carried out in line with trust policy and national guidance on five out of six occasions.

Staff did not always observe patients who needed additional monitoring. In the Medical Assessment unit an acutely psychotic patient was supposed to be provided with one to one support. The staff member was unfamiliar with the patients’ condition or symptoms. Despite this level of supervision, the healthcare assistant kept leaving the patients’ side room door. The patient was distressed and attempted to leave the ward on many occasions.

Nurse staffing

The service did not have always 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.

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in medicine.

The overall fill rate for qualified nursing staff remained similar at 85.7% in March 2018 and 83.3% in June 2018.
### Staffing Fill Rates

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>March 2018</th>
<th>Fill Rate</th>
<th>June 2018</th>
<th>June 2018</th>
<th>Fill Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td></td>
<td>Actual</td>
<td>Planned</td>
<td></td>
</tr>
<tr>
<td></td>
<td>staff –</td>
<td>staff –</td>
<td>Fill Rate</td>
<td>staff –</td>
<td>staff –</td>
<td>Fill Rate</td>
</tr>
<tr>
<td></td>
<td>WTE in</td>
<td>WTE</td>
<td></td>
<td>WTE in</td>
<td>WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>month</td>
<td></td>
<td></td>
<td>month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>919.5</td>
<td>966.8</td>
<td>95.1%</td>
<td>889.3</td>
<td>1,009.6</td>
<td>88.1%</td>
</tr>
<tr>
<td>Birmingham Heartlands</td>
<td>528.1</td>
<td>640.4</td>
<td>82.5%</td>
<td>533.0</td>
<td>653.7</td>
<td>81.5%</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>266.0</td>
<td>384.7</td>
<td>69.1%</td>
<td>263.6</td>
<td>355.5</td>
<td>74.2%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>192.2</td>
<td>235.4</td>
<td>81.7%</td>
<td>191.5</td>
<td>239.6</td>
<td>79.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

Staffing fill rates were low at Good Hope Hospital, but had improved between March 2018 and June 2018.

### Vacancy Rates

From April 2017 to March 2018, the trust reported a vacancy rate of 17.3% for nursing staff in medicine. This was higher than the trust target of 5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors vacancy rates for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 9.5%
- Birmingham Heartlands Hospital: 17.7%
- Good Hope Hospital: 26.6%
- Solihull Hospital: 15.2%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The vacancy rates were especially high at Good Hope Hospital which put pressure on staffing the wards. On inspection we found that registered nurse vacancy rates were high on the medical wards, nurses on the respiratory ward told us that the ward had a 67% vacancy rate and that they relied upon agency and bank staff to fill shifts and to try and maintain safe staff levels.

### Turnover Rates

From April 2017 to March 2018, the trust reported a turnover rate of 9.7% for qualified nursing staff in medicine. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 4.2%
- Birmingham Heartlands Hospital: 14.9%
• Good Hope Hospital: 15.5%
• Solihull Hospital: 16.6%
• Community locations: 13.2%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 4.7% for qualified nursing staff in medicine. This is above the trust targets of 3.6% for Queen Elizabeth Hospital and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

• Queen Elizabeth Hospital: 4.5%
• Birmingham Heartlands Hospital: 5.4%
• Good Hope Hospital: 4.2%
• Solihull Hospital: 4.7%
• Community locations: 2.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From April 2017 to March 2018 the trust reported that for qualified and unqualified nursing staff 5.1% of actual hours were filled by agency staff and 21.5% by bank staff across Birmingham Heartlands, Good Hope and Solihull hospitals. The number of unfilled hours, a breakdown by site and staffing type was not provided.

(Source: Nursing bank agency - HGS PIR Return)

Staffing levels were described to us as unsafe by staff members of all grades across most wards. Staff told us most wards operated below planned levels most of the time. On the days we visited eight out of eleven wards were operating below planned levels. When wards were not short staffed, staff members were moved to other wards where staffing was low which could create a risk on the wards they were being moved from.

Staff regularly reported incidents when they were short staffed. There were 66 incidents that were reported via datix by staff between 1 November 2017 and 30 September 2018 that reported low staffing levels on medical wards, these include many reports of unsafe situations as described by the reporting nurse. These incidents broken down by ward are; Ward 9 (19), Ward 12 (19), Ward 10 (9), Ward 11 (8), Flexible ward and other (4), Ward 21 (3), Ward 7 (2), assessment medical unit (2). Most of these reports were done with nurse staffing establishment at 50% and anything above that was seen as usual a lot of the time. The concerns raised by staff on these incidents included; unsafe staffing due to staff being moved from the ward, nursing level at 1 nurse to 16/17 patients, staff not taking any breaks whilst on shift, high risk falls patients not being monitored effectively, medications given late, observations done late, lack of non-invasive ventilator (NIV) trained staff on ward and confused patients wandering around the ward.

Staff reported incidents, through the trust electronic incident reporting system, when they were short staffed. Between 1 November 2017 and 30 September 2018, 66 incidents had been reported with wards 9 and 12 the highest reporters at 19 each and wards 7 and the Medical Assessment unit the lowest at two each. Our review of these incidents indicated nursing staff were only raising incidents when the planned staffing level was reduced by 50% or less. We were not therefore
assured incidents relating to low staffing levels were raised appropriately. As a result of planned staffing levels not always being met, patients were not always protected from avoidable harm. Concerns raised through incident reports included; unsafe staffing due to staff being moved from the ward, nurse staffing level at one nurse to 16/17 patients, staff not taking any breaks whilst on shift, high risk falls patients not being monitored effectively, medications given late, observations done late, lack of non-invasive ventilator (NIV) trained staff on ward and confused patients wandering around the ward.

Bank and agency usage was high on the wards. Staff told us bank and agency use was high on the wards and that often on a shift there would be only one permanent trust nurse. Staff felt the changes in bank pay structure had an impact with bank staff less likely to pick up as many shifts as before.

Handovers were comprehensive and recorded. Staff of all grades, including bank and agency attended handover. The one handover we saw included was detailed and comprehensive. Staff told us handovers were of good quality and included all the information necessary to provide safe and effective care to their patients. The handover notes we looked at were very comprehensive and included updates from all types of staff. All staff told us that bank and agency staff always received a handover and were introduced to the patients that they were caring for.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in medicine.

The overall fill rate for medical staff dropped from 89.3% in March 2018 to 88.2% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>317.2</td>
<td>321.8</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>225.0</td>
<td>251.1</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>75.3</td>
<td>110.8</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>62.6</td>
<td>78.0</td>
</tr>
</tbody>
</table>

Good Hope hospital had a low fill rate for medical staff and this number had reduced between March and June 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 11.8% for medical staff in medicine. This was higher than the trust target of 10% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.
The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors vacancy rates for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: -0.9% (over staffed)
- Birmingham Heartlands Hospital: 10.1%
- Good Hope Hospital: 28.7%
- Solihull Hospital: 16.0%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 4.2% for medical staff in medicine. This is below the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 2.3%
- Birmingham Heartlands Hospital: 11.1%
- Good Hope Hospital: 12.4%
- Solihull Hospital: 10.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 0.8% for medical staff in medicine. This is below the trust targets of 3.6% for Queen Elizabeth Hospital and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

A breakdown by site is below:

- Queen Elizabeth Hospital: 0.8%
- Birmingham Heartlands Hospital: 0.6%
- Good Hope Hospital: 0.7%
- Solihull Hospital: 1.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.
From April 2017 to March 2018 the trust reported that 15,816 shifts were filled by locum medical staff, 7,741 by bank medical staff and that 3,125 were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Locum</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>4,959</td>
<td>2,574</td>
<td>752</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>3,707</td>
<td>2,784</td>
<td>678</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>6,263</td>
<td>1,267</td>
<td>1,559</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>887</td>
<td>1,116</td>
<td>136</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In May 2018, the proportion of consultant staff and junior (foundation year 1-2) reported to be working at the trust was similar to the England average.

Staffing skill mix for the 732 whole time equivalent staff working in medicine at University Hospitals Birmingham NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>30%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>21%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

Source: NHS Digital - Workforce Statistics - Medical (01/05/2018 - 31/05/2018)

Medical staffing was at a reasonable level and kept people safe from harm. Medical staff we spoke with said staffing levels were reasonable at the trust and that their workload was manageable. However, data provided by the trust showed a vacancy rate of 28.7% for medical staff. Nursing staff told us that consultants and juniors were responsive and always available when needed. Between the dates of 1 November 2017 and 30 September 2018 there were no reports of low medical staffing reported through the trust incident reporting system.

Handovers were comprehensive and recorded. Medical staff of all grades, including locum staff, attended handover. Staff told us handovers were of good quality and included all the information necessary to deliver safe and effective patient care. We observed a handover on the Medical Assessment unit. We saw the handover covered the status of all patients, bed availability in the hospital and wider trust as well as individual roles of those present.

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

Patients care records were legible, up to date and included the appropriate documentation needed. We reviewed 29 patient care records across the wards we visited and saw that they contained appropriate patient-centred risk assessments, were organised and could be understood by bank and agency staff who were new to the ward. Where appropriate patient records contained good input from specialist teams. Additional needs, such as dementia, were noted in care records.

Staff stored patients records securely. Patient information was stored securely in locked cabinets on the wards which were kept in the nurse’s office when not in use.

Staff completed ‘do no attempt cardio-pulmonary resuscitation’ (DNACPR) paperwork appropriately. We reviewed two DNACPR records and we saw that reasoning for the decisions was well documented, discussions with patients families were included and that the clinician regularly signed and dated the forms.

Patient care records included pressure ulcer prevention and management documentation. We saw that patients had a skin viability assessment completed on admission and that patients with a pressure ulcer had appropriate care plans in place, which included positioning regimes and additional equipment support.

Patient records contained appropriate patient transfer information. Transfer documentation for patients provided all the information needed for the patient’s ongoing care to ensure information was shared appropriately. We saw that transfer documents were completed for patients moving between different wards at the hospital and observed that these were sufficiently detailed and filled in appropriately.

**Medicines**

The service did not always follow best practice when prescribing and giving medicines. The service did not always follow best practice when recording and storing medicines. Patients mostly received the right medication at the right dose at the right time.

Staff kept medicines on the wards in good order. The pharmacist, at the request of staff on the wards, stocked the medicines trolleys. We observed that medicine trolleys were always locked as were the doors to clinic rooms. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Controlled drugs we checked were stored and managed appropriately.

Emergency medicines on resus trolleys was well maintained and in date. We checked six resuscitation trolleys and found that all emergency medicines were within date.

Staff utilised the e-prescribing system and it worked well on the wards. The wards we visited used an e-prescribing system which worked well. All staff we spoke with said they were happy with how the e-prescribing system worked and it was observed to work well. As a safeguard prompt, an allergy status had to be entered into the e-prescribing system before the user could administer any medicines. Some drugs were not prescribed through the e-prescribing system. The paperwork we checked in care records that included these drugs was completed correctly and had allergy information included.

Medicines requiring refrigerated storage were not always stored at the correct temperatures to ensure they were fit for use. Refrigerators to store medicines should maintain an air temperature of two to eight degrees Celsius. Average/mean monthly fridge or room temperatures were not
recorded or visible on any of the medical wards we visited. On ward 11 there were two different devices for measuring temperatures which gave different readings. On ward 24 the maximum reading of the fridge temperature was recorded at 21 degrees for the whole of September, the ward manager was not aware and nothing had not been reported. Staff understanding around the implications of this was also limited to just reporting to the pharmacy team, although it was not clear what would trigger them to do this.

There was a high level of medicines incidents on the wards. There were 294 medicines incidents between September 2017 and October 2018 across the 11 wards. The Medical Assessment unit reported the most incidents at 64 and ward 21 at 11. Out of the 294 incidents, 25 (8.5%) had resulted in harm, one of which was severe. The most common categories were; other medication incidents (74), missing medication (44), incorrect storage of medication (28), wrong dose/strength (28) and missing controlled drugs (24). Staff had taken actions when incidents had occurred and these were noted in the datix reports.

Staff ensured patients were given their medicines in a timely manner. The hospital used a bleep service to remind staff to administer ‘time-critical’ medicines such as Parkinson’s and diabetes medicines. An alarm would continue to sound until the patient had received the medicine.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service, although staff did not always receive feedback. When things went wrong, staff apologised and gave patients honest information and suitable support.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From April 2018 to July 2018, the trust reported no incidents classified as a never event for medicine.

(Source: NHS Improvement - OBIEE NRLS STEIS (01/04/2018 - 31/07/2018)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 33 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from April 2018 to July 2018.
The breakdown by type of incident reported were:
- Slips/trips/falls meeting SI criteria with 20 (60.6% of total incidents)
- HCAI/Infection control incident meeting SI criteria with eight (24.2% of total incidents)
- Treatment delay with two (6.1% of total incidents)
- Pressure ulcer with two (6.1% of total incidents)
- Confidential information leak/information governance breach with one (3.0% of total incidents).

Site specific information can be found below:
- Queen Elizabeth Hospital: 14 incidents (42.4%)
- Good Hope Hospital: 12 incidents (36.4%)
- Birmingham Heartlands Hospital: five incidents (15.2%)
- Solihull Hospital: two incidents (6.1%)

(Source: Strategic Executive Information System (STEIS))

Staff reported incidents electronically. The trust used an electronic incident reporting system and staff we spoke with knew how to report incidents.

Staff managed incidents well but did not always receive feedback. Staff, including the people responsible for investigating incidents, knew their duties when it came to reporting incidents and could describe the process and provide examples of when they had done so. However, three staff members reported they did not always receive feedback from incidents, particularly when they were related to staffing.

Learning was shared between wards and other hospitals within the trust. Staff provided examples of when and how learning was shared with divisions, the hospital and the wider trust. Learning from clinical incidents was shared in a variety of ways including at team briefs, team meetings, notices in the staff room and through email.

Staff had a good understanding of duty of candour. Staff we spoke with all understood what was meant by duty of candour and could give clear examples of when it would be used. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. The service had a duty of candour policy available to staff on the trust intranet.
Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from April 2018 to July 2018 for medical services as all incidents were reported under the core service ‘Other’.

(Source: NHS Digital - Safety Thermometer)

Medical wards experienced a high level of falls. Between October 2017 and September 2018 there were 904 falls across the 11 wards we inspected. Ward 9 had the highest number of falls at 123 and ward 7 the lowest number at 48. Of the 904 falls, 22 falls had resulted in severe harm and 34.5% of falls had occurred when patients were unobserved by staff. We were not assured therefore; staffing levels were high enough for staff to monitor patients effectively. Staff attempted to reduce the risk of falls by cohorting patients in the same area (putting patients at high risk of falls together so they could be more easily observed).

Staff used monitoring results well and used this to improve patient safety. Many of the elderly care wards had not had any avoidable grade 2 or 3 pressure ulcers for over a year.

Staff displayed safety data on the wards for patients and visitors to see. Safety data was clearly visible on most wards we visited and included information such as falls, pressure ulcers and audit results.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff had access to the relevant guidance they needed. All the relevant guidance, such as neutropenic sepsis, antibiotic and stable chronic obstructive pulmonary disease guidance, was in place and mostly in date and accessible on the trust intranet. However, we did see that acute severe asthma guidelines went out of date in August 2016 and hyperaemia guidance went out of date in February 2018.

Staff could not always access information in a fast way. Staff told us that the hospitals intranet and internet was often slow which limited the speed at which they could access the information they needed, we also saw this was the case when we tested it.

Staff assessed patients’ needs in line with best practice. Staff delivered treatment and assessment in line with legislation, standards and evidence-based guidance including guidance from the National Institute of Clinical Excellence (NICE), such as dementia, diabetes and sepsis. NICE provides national guidance and advice to improve health and social care. Staff followed best practice in care records we reviewed, including in areas such as sepsis management and pressure ulcers.

Staff did not discriminate against protected characteristics. Staff did not discriminate on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation when making care and treatment decisions. Staff and patients reported no concerns about this.

Staff protected people’s rights with regards to the Mental Health Act (MHA). Patients who were receiving healthcare whilst detained under the MHA had their rights protected. Staff mostly managed paperwork correctly. However, two staff members we spoke with were not fully aware of the process in place with regards to MHA paperwork.

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 preferences.

Staff assessed patients nutrition and hydration needs. Staff carried out nutrition and hydration assessments on all patients on admission to the hospital and these assessments were evidenced in the care plan. Staff continued to assess nutrition and hydration needs as necessary and food and fluid levels were monitored.

Staff had access to dietician services. Staff told us they could access a dietitian if required. Staff told us this service was responsive.

Patients’ food choices were taken into account and food was of good quality. Patients’ religious and cultural needs were taken into account when ordering food. The hospital also offered vegetarian options for patients. All patients told us the food was of good quality. The hospital carried out a meals audit between May and September 2018 across several wards, which had an average score of 94.2%.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.
Staff monitored patients’ pain regularly. Staff always assessed patients’ pain during observations and we saw this during our review of observation charts.

Staff administered pain relief when a patient needed it. All patients and staff told us that whenever they needed any pain relief it was administered at the earliest possible opportunity.

**Patient outcomes**

The following patient outcome audits were carried out prior to the acquisition of University Hospital Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust and have therefore not been included in this report. Results from these audits cannot be used to form part of our judgement for this service.

As the trust underwent an acquisition in April 2018 we are unable to analyse the relative risk of readmission for elective and non-elective admissions as this uses a 12-month time period.

**Sentinel Stroke National Audit Programme (SSNAP)**

The most recent reporting period for the SSNAP audit was carried out prior to the acquisition of Heart of England NHS Foundation Trust by University Hospital Birmingham NHS Foundation Trust and has therefore not been included in this report.

(Source: Royal College of Physicians London, SSNAP audit)

**Lung Cancer Audit**

The 2017 Lung Cancer audit was carried out prior to the acquisition of Heart of England NHS Foundation Trust by University Hospital Birmingham NHS Foundation Trust and has therefore not been included in this report.

(Source: National Lung Cancer Audit)

**National Audit of Inpatient Falls 2017**

The 2017 National Audit of Inpatient Falls was carried out prior to the acquisition of Heart of England NHS Foundation Trust by University Hospital Birmingham NHS Foundation Trust and has therefore not been included in this report.

(Source: Royal College of Physicians)

**Competent staff**

The service made sure staff were competent for their roles. Managers mostly appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

**Appraisal rates**

From April 2017 to March 2018, 89.1% of staff within medicine at the trust received an appraisal. This is below the trust target for Queen Elizabeth Hospital of 90% but above the target for other sites of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Good Hope Hospital

From April 2017 to March 2018, 81.9% of staff within medicine at Good Hope Hospital received an appraisal compared to a target of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental staff</td>
<td>294</td>
<td>300</td>
<td>98.0%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>116</td>
<td>120</td>
<td>96.7%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>285</td>
<td>305</td>
<td>93.4%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>554</td>
<td>607</td>
<td>91.3%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>599</td>
<td>662</td>
<td>90.5%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>274</td>
<td>303</td>
<td>90.4%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>651</td>
<td>733</td>
<td>88.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>1,796</td>
<td>2,100</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

Qualified nursing & health visiting staff failed to meet the target completion rate.

Staff mostly had regular appraisals and they were of good quality. Qualified nursing and health visiting staff and NHS infrastructure support, the two largest staff groups, were below the trust target for appraisals of 85%. Most staff told us that appraisals were of good quality and felt they were worthwhile and beneficial, however two staff members told us they felt the appraisals were a tick box exercise.

Nursing staff had the opportunity to progress and develop. Most nursing staff from all bands told us they had access to any specialist and further training they wanted. Staff told us they could approach managers in appraisals as well as on a day to day basis if they wanted any new training. Junior nursing staff also told us more senior staff were always approachable when they had anything they wanted to ask.

Agency staff were not always as effective as they could be. Permanent staff told us that often agency staff did not have sufficient specialist training to work as effectively as possible on some wards. This created a higher workload for permanent staff as agency nurses could not carry out all nursing tasks, for example non-invasive ventilation monitoring.

Medical staff had lots of learning opportunities. Junior doctors had access to regular scheduled training, as well as engaging in development on the wards with case reviews and informal learning.

Managers managed performance issues of their staff on the ward. Managers told us how they managed performance issues through informal supervision and appraisal.

**Multidisciplinary working**
Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

All necessary staff were involved in people’s care. All necessary staff members were involved in assessing, planning and delivering people’s care and treatment. This included medical staff, nursing staff, pharmacists, occupational therapists and social workers. All staff groups told us and we saw on inspection that all staff groups worked well together, were involved in handovers and supported each other when needed.

When patients moved between wards and were discharged care was co-ordinated well. Most staff and all patients told us that when patients moved between wards and services or were discharged it was handled well. However, we were told about occasions when patients were moved despite the receiving ward not being in a position to take the patient. The discharge lounge had an out of hours (OOH) policy. Staff worked to reduce delays mostly attributed to pharmacy and ambulance issues.

Seven-day services

There was access to the appropriate services seven days a week.

There was access to pharmacy and physio services seven days a week. Pharmacists, occupational therapists and physiotherapists were available Monday to Friday on the wards. There was also cover provided at weekends and out of hours.

There was access to mental health support seven days a week. The service had access to mental health support seven days a week through the Rapid Assessment Interface and Discharge team. This meant patients had access to timely assessments and reviews to support their needs.

Other teams were also accessible at weekends. Teams such as palliative care had an on call weekend service as well as being available Monday to Friday.

Health promotion

Patients were signposted to various services to promote their health and wellbeing. For example, staff told us that patients who smoked were offered information about the NHS stop smoking service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Mental Capacity Act and Deprivation of Liberty training completion

The trust combines safeguarding level 2, mental capacity and deprivation of liberty (DOLs) training.

Good Hope Hospital

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>


The trust’s 90% completion target was met for this training module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in medicine at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>61</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this training module.

Staff mostly had the relevant training to be effective in this area. Nursing staff met the mandatory training target in the area of DoLS and mental capacity but medical staff did not. However, medical staff were at an 83.6% completion rate. The DoLS protect people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

Staff mostly had a good understanding of the Mental Capacity Act (MCA). Most staff we spoke with had a good understanding of the MCA. Staff also knew where to find further information if they needed it and would seek help from their ward manager if needed. Patients mental capacity was assessed and ability to consent was assessed and where appropriate, recorded.

Staff mostly had a good understanding of Deprivation of Liberty Safeguards (DoLS). Most staff we spoke with had a good understanding of DoLS. Staff told us and we saw examples of staff on the wards managing patients under DoLS appropriately.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 27.1% which was better than the England average of 24.8% from April 2018 to June 2018.

Good Hope Hospital

The Friends and Family Test response rate for medicine at the Good Hope Hospital was 35.3%. A breakdown by ward is below (please note, only wards with at least 100 responses are shown).
### Table

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMU Assessment</td>
<td>355</td>
<td>47%</td>
<td>95%</td>
</tr>
<tr>
<td>AMU Short Stay</td>
<td>165</td>
<td>22%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 7</td>
<td>137</td>
<td>38%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 8</td>
<td>155</td>
<td>53%</td>
<td>85%</td>
</tr>
<tr>
<td>Ward 21</td>
<td>195</td>
<td>74%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Only ward 8 (diabetes/gastroenterology) had a recommended rate of under 90% for April to June 2018.

(Source: NHS England Friends and Family Test)

Staff demonstrated a supportive and caring attitude with patients. All patients told us staff treated them with a caring and supportive attitude. Most patients said staff worked well despite short staffing levels. Some patients gave examples of where staff went out of their way to do positive things such as sing happy birthday to them. We saw staff treating patients in a supportive and caring way. We saw staff helping patients to mobilise and ensuring that they assisted patients at their own pace and were patient and kindness. There were cards displayed on many of the wards that visited praising the staff for the care they had given patients.

Senior staff audited the caring nature of interactions ward staff had with patients. Staff underwent observations in care reports, where senior nurses assessed care with actions being categorised as positively enriching, enriching, neutral, negatively controlling and negatively restricting. We saw the August results for ward 10 and they came out with 67.1% positively enriching or enriching, 31.4% neutral and 1.4% negatively controlling. However, some staff told us that due to low staffing levels not all patients received the level of personal care they would like to offer.

Staff treated patients with dignity and respected patients privacy. All Patients told us staff always treated them with dignity and respect. Staff always respected patients privacy when it came to physical and intimate care.

Staff understood and respected patients personal needs. All Patients told us that staff respected their personal, cultural, social and religious needs.

### Emotional support

**Staff mostly provided emotional support to patients to minimise their distress.**

Staff mostly responded to patients emotional distress in a kind way. All patients told us staff would respond as soon as they could to any emotional distress and they gave examples of when they had experienced distress and were responded to in a kind way. We saw staff responding as quickly as they possibly could to any patients emotional distress, however on one occasion on ward 11 a patient was left whilst crying out in distress and staff did not respond in a timely way.

Staff supported patients to manage their own healthcare and wellbeing where possible. Staff always empowered patients to manage their own healthcare where appropriate. We saw the level of personal care required noted in care records so staff knew what help people required.
Staff enabled patients to have contact with people close to them. Staff spoke with patients families on the phone and always enabled patients to have contact with relatives wherever possible. We heard an example of a staff team making extra effort to get the correct person of contact for someone whose relatives lived out of the area.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

Staff communicated with people about their care and treatment conditions. All patients said staff explained decisions about their care and treatment to them. Patients told us that when they were moved between wards the reason was always explained to them.

Staff communicated with relatives and carers about care and treatment. All relatives and carers we spoke with said they were kept informed by Doctors and Nurses on the wards. Staff would answer any questions that relatives and carers had as soon as they could.

Staff recognised when patients needed additional support and it would be provided. Staff recognised when patients needed access to further support, such as speech and language therapists and dieticians and always referred them to these services so they could access the support.

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**Is the service responsive?**

**Service delivery to meet the needs of local people**

*The trust planned and provided some services in a way that met the needs of local people.*

**Average length of stay**

As the trust underwent an acquisition in April 2018 we are unable to analyse the average length of stay for elective and non-elective admissions as this uses a 12-month time period.

(Source: Hospital Episode Statistics)

The hospital set up wards to reflect the needs of the local population. The service reflected the needs of the ageing population it served by introducing a frailty ward which had the patients most likely to need additional support due to conditions relating to older age or at greater risk of falls. The hospital had also set up a short stay acute medical ward which used to be flexible which took patients for a variety of reasons and helped to take the pressure off other wards by taking patients who would not be admitted to hospital for a longer period of time.

The hospital had taken some measures to consider patients with dementia. The wards had large, red signs on the wards toilets.

The hospital engaged with people in vulnerable circumstances. Staff could make a referral to a homelessness liaison nurse if it was required.

**Meeting people’s individual needs**

*The service took account of patients’ individual needs.*

Services are planned in a way that takes account of people’s individual needs. The services were planned in a way so they accounted for people’s age, gender, gender reassignment, pregnancy and maternity status, race, religion and sexual orientation. The hospital offered food that met any individual needs that were required. Patients could access to whatever spiritual support you may
want, via the onsite chaplaincy service. The hospital had access to translation services if they needed them, which staff described as very responsive.

Services are planned in a way that takes into account people's complex needs. The services were planned in a way that met patient's complex needs, such as dementia and diabetes. Patients could be referred to a specialist diabetes nurse, staff said they were very responsive. The hospital had a dementia and delirium team that could be accessed who were also planning extra specialist training for staff. However, the service did not use dementia friendly signs above beds or 'forget me not' or butterfly schemes.

Staff had access to translation services for people whose first language was not English. Translation services were available for patients whose first language was not English, this could be accessed by telephone or face to face. Staff told us they knew how to use this service.

The service made reasonable adjustments so that disabled people could access the service. The building was fully accessible for disabled people. The wards had the appropriate equipment to help people with disabilities such as hoists.

**Access and flow**

Patients could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From April to June 2018 the trust's referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.

![Graph showing referral to treatment times]

**Referral to treatment (percentage within 18 weeks) – by specialty**

Seven specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for April to June 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>100.0%</td>
<td>94.4%</td>
</tr>
<tr>
<td>General medicine</td>
<td>97.7%</td>
<td>97.1%</td>
</tr>
<tr>
<td>Neurology</td>
<td>96.7%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>96.6%</td>
<td>94.9%</td>
</tr>
<tr>
<td>Specialty</td>
<td>Result</td>
<td>England Average</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Cardiology</td>
<td>91.6%</td>
<td>80.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>83.5%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for April to June 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>92.3%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Patient moving wards per admission**

From April 2017 to March 2018 the trust did not report any patient moves for non-clinical reasons in medicine.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Patient moving wards at night**

The trust reported the ward moves at night data separately for all sites.

**Good Hope Hospital**

From July 2017 to June 2018, there were 1,000 patient moving wards at night within medicine.

The wards with the highest number of ward moves at night were:

- Short Stay Assessment with 219 moves (21.9%)
- Ward 23 - Cardiology with 122 moves (12.2%)
- Ward 22 – Elderly care with 113 moves (11.3%)

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Staff informed patients when they were being moved at night and it was only ever done for clinical reasons or because of someone in urgent need.

Staff prioritised care and treatment for those who had the most urgent need. Staff told us that patients in the greatest need were moved into the most appropriate beds as soon as they could be. However, this sometimes left patients waiting in corridors either to move into beds on the wards or to be discharged. Staff sometimes felt pressured to take patients before they had capacity on wards.

Staff within the service planned ahead. Leaders of other wards would look at the patient list in assessment medical unit to see which patients would potentially be moving onto their wards in the near future so they could look at bed occupancy and who will be discharged.

Staff had access to a complex discharge team. The service had a complex discharge team who assisted the wards with complex discharges including patients requiring rehabilitation, community beds and care packages. Staff were aware of how to refer to the discharge liaison team and told us that they came responsively.

The hospital tried to prevent avoidable admissions when possible. The hospital had a rapid assessment, interface and discharge (RAID) team onsite who provide an in-reach psychiatric liaison service to prevent avoidable admissions to inpatients. RAID is a multidisciplinary service
integrated within the general hospital that provides a single point of access available 24 hours a day and open to all patients over 16 with mental health and drug and alcohol problems presenting to acute care. Staff were aware of how to use RAID and we heard how two patients had been referred to the RAID team.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

**Summary of complaints**

**Trust level**

From April 2017 to March 2018 there were 201 complaints about medical care across the trust as a whole. The trust took an average of 42 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Of the 25 complaints still open at the time of reporting all had been open longer than the trust target of 30 working days, the longest being open for 231 working days.

A breakdown by site is below:

- **Queen Elizabeth Hospital:** There were 104 complaints, the main themes were patient care with 30 complaints (28.8%), clinical treatment with 20 complaints (19.2%), communications with 18 complaints (17.3%) and admissions, discharges and transfers with 13 complaints (12.5%)

- **Birmingham Heartlands Hospital:** There were 48 complaints, the main themes were all aspects of clinical treatment with 28 complaints (58.3%) and admissions, discharge and transfer arrangements with 11 complaints (22.9%)

- **Good Hope Hospital:** There were 35 complaints, the main themes were all aspects of clinical treatment with 16 complaints (45.7%), communication/information to patients with five complaints (14.3%) and admissions, discharge and transfer arrangements with four complaints (11.4%)

- **Solihull Hospital:** There were 14 complaints, the main theme was all aspects of clinical treatment with eight complaints (57.1%)

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 727 compliments within medicine.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>689</td>
<td>94.8%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>20</td>
<td>2.8%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>9</td>
<td>1.2%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>7</td>
<td>1.0%</td>
</tr>
<tr>
<td>Birmingham Chest Clinic</td>
<td>1</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
Patients who used the services knew how to make complaints. All the patients we spoke said that if they wanted to make a complaint about the service they would know what to do and would do so without fear.

Staff treat patients who complain with compassion and kept them up to date. Staff made sure they responded quickly to patients’ official complaints with a phone call to make sure the patient was ok and inform them that the complaint has been picked up and is being investigated and provide a timeframe. This also gave the complainant a point of contact if they needed it.

There was openness and transparency when dealing with complaints. Ward managers and other staff on the wards gave examples of when they had been involved in complaints and how they had maintained openness and honesty. Ward managers or matrons investigated complaints.

The hospital learnt lessons from complaints. Staff gave examples of where they had learnt lessons from complaints and had learning shared with them. One example was the introduction of the Jean Robinson award which is given by the family of a former patient to one of the elderly care wards each year. The family of Jean Robinson who give out the award were originally complainants and now work with the wards to drive improvement.

**Is the service well-led?**

**Leadership**

Managers mostly had the right skills, knowledge and abilities to run a service providing high-quality sustainable care.

Managers at ward level had the knowledge and experience to run the wards. Ward managers we spoke with demonstrated the knowledge the needed to run the wards as best they could. Ward managers had the experience they needed to run the wards as effectively as they could with the resources they had.

Managers mostly understood the challenges they faced. Ward managers had a good understanding of the major issues they faced on their wards and did their best to try and deal with the challenges. Managers above ward level mostly understood the challenges they faced.

Some managers were visible at ward level. Ward managers and middle managers were visible on the wards and would help out with nursing staff duties if it was required. However, most staff told us they had never seen anyone from the trust board and would only recognise them based on pictures.

Ward managers were approachable and supportive. Staff told us that their managers were approachable and supportive. Staff told us managers do not stay in their offices and are always on the wards. Ward managers supported staff with issues they had and supported and encouraged staff to do further learning and development.

Ward 10 was without a ward manager and lacked leadership which was affecting the team negatively. Ward 10 had lots of ward managers in quick succession and at the time of inspection had no one in place. Staff told us and we saw this, combined with staffing problems, was having a negative impact on the ward.

**Vision and strategy**
The trust had a vision for what it wanted to achieve, not all staff were aware of it. The trust had plans to turn it into action.

The trust had the vision to build healthier lives. To build healthier lives, they were guided by five values or principles that define and shape their working practices. The five principles were collaborative, honest, accountable, innovative and respectful.

Some staff within the service were aware of the trust's values. Some staff within the service were aware of the values and most members of staff that we spoke with could name them. However, some staff were not aware of these specific values

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff mostly felt respected and valued. Most staff told us they felt respected and valued within their services and by their managers. On ward 12 the ward manager has implemented ideas such as ‘quote of the day’ and ‘staff member of the week’ to increase staff morale on the ward.

The culture centred on the needs and experience of patients who use services. The culture on the wards was centred around the needs of patients. Staff were focussed on the needs of patients and a safe, positive patient experience.

The culture mostly encourages candour, openness and honesty. Staff had a good knowledge of duty of candour and were able to provide examples of when they had used it or would use it. Staff spoke to us about the issues they faced with openness and honesty. However, staff had poor knowledge of the freedom to speak up guardian and what the purpose of the role was.

The trust put a strong emphasis on staff wellbeing. The hospital had a counselling service that was available for staff to use confidentially anytime. The counselling service also did ward visits when there was a serious incident on wards to make sure that staff's wellbeing was maintained. The trust had a health and wellbeing centre that had seen over 600 members of staff. The trust also have a financial wellbeing initiative for staff which covered areas such as affordable loans, debt advice and savings. We heard from most staff members that returning to work from sickness was a positive experience and managers did everything they could to help, however we heard about when occasion where this was not the case.

**Governance**

The trust's governance systems failed to ensure it met lots of basic safety standards and safeguard people from harm.

Performance was monitored through quality and safety groups. Senior leaders within the service told us that the service's performance was reported on a monthly basis through the quality and safety meetings. The service, which was split between two divisions, had separate reporting structures but they held these joint meetings. Learning was also shared at these meeting which could be disseminated down to ward managers and ward level staff. The trust then provided monthly performance reports for the board so they could be discussed.

Ward to board dashboards are produced which provide a wide range of information in simple format. Ward to board dashboards were produced from planning and performance manager. These were then disseminated to nurses on the wards and contained 32 elements. This data is presented in a simple single page format for staff. Most wards displayed this information for members of the public and patients to see. Ward to board dashboards contained information on harm free care, inpatient falls, tissue viability, venousthromboembalism (VTE), medication and
Care quality metrics. Care quality metrics included; environment, patients safety, dignity, observations, fluid balance, nutritional assessments, manual handling continence assessments and blood glucose monitoring.

These governance structures did not always flag harm. The governance structures that were in place failed to protect some patients from avoidable harm. As the governance processes did not always flag issues around falls and medicines management the appropriate actions could not be taken to address them.

Staff were clear in their roles and knew who they were accountable. Most staff we spoke with knew what their role was on the wards and knew who they were accountable to. Staff also knew who to go to if they had issues with the person to whom they were directly accountable to.

There were regular staff meetings on most wards. Most staff on the wards that we visited told us that they had monthly or bimonthly meetings in which they would discuss topics such as incidents on the wards, learning from other wards, audit results and general ward issues.

Management of risk, issues and performance

The trust did not have an effective system for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a systematic programme of internal audit to monitor quality and operational processes. Staff across all wards and bands told us they were involved in ward level audits that covered areas such as documentation, environment, cleanliness, falls, tissue viability and medicines management. The waste management audit had no actions marked despite only having a score of 71% positive.

The trust had a clear structure laid out for who reports to who with regards to risk management. The trusts structure with regards to risk management and board assurance was clear. It included who was responsible for informing, scrutinising and assuring who with regards to risk. Senior leaders within the service were mostly sighted on the risks within the service, however some of the areas where we found concerns were not highlighted on the risk register or mentioned to us, such as falls for example.

The trust had risk registers split by division. There were two different divisional risk registers that were aligned to the wards we inspected. Division three contained the assessment medical wards, cardiology, respiratory, stroke and the flex 22 ward. The flex 22 ward is a six bedded ward which is used as an overflow to help with capacity issues. Division four contained all the elderly care, frailty and the diabetes/gastroenterology wards. These risk registers covered Good Hope Hospital, Solihull Hospital and Birmingham Heartlands hospital so were not only specific to this site. These risk registers ranked impact based on a scale of 1 – 25, with 25 being the biggest risk.

The service leads were aware of their workforce shortages and identified this as their primary risk. The risk was documented on the risk register and was given a high priority rating. The division three risk register highlighted ‘Qualified Nurse Vacancies, maternity leave and skill mix impacting on service delivery’ across its acute medicine sector with a risk score of 15. They also identified ‘overcrowding and delayed treatment in an understaffed ward - patient safety risk’ as an issue on the respiratory ward with a score of six. These highlighted that the trust are aware of issues relating to staffing. The divisional lead also highlighted staffing vacancies as the biggest risk. However, based on the vacancy levels and lack of a ward manager on the respiratory ward that risk score of six is low compared to the current risk. The division four risk register highlighted staffing issues on the wards and the divisional lead was aware. The division four risk register highlighted ‘Shortage of Nursing Staff in Elderly Care Leading to Risk of Poor Quality of Patient
Care’ which was a trust wide risk with a score of 16. It also highlighted ‘Shortage of Medical Staffing and Transferring of Patients Leading to Risk of Poor Quality of Patient Care’ which was specific to Good Hope Hospital and had a risk score of 15.

Risks we have identified on inspection and through data were not mentioned to us by senior leaders or seen on the risk register. Senior leaders and staff did not highlight high levels of falls or high medication errors as a risk whilst on site and these were not present on the risk register. Issues relating to waste management, windows opening too far, incorrect monitoring of fridge temperatures and open store rooms were not known to trust leaders.

The trust had a plan to deal with upcoming winter pressures. There are plans in place to utilise a currently empty ward and have a 25 bedded unit that will open in December 2018 and remain open until Easter 2019 in order to alleviate some of the winter pressures. This ward will sit under division four. Senior leaders were recruiting staff at the time of inspection and attempting to get agency staff booked on for a four month block. However, some staff members were extremely worried about the hospitals ability to cope with winter pressures and worried staff would be taken away from already understaffed wards.

**Information management**

The trust did not collect and manage information well to support its activities.

The service had clear service performance measures which were regularly reported and monitored on using the ward to board dashboards. The dashboard monitored the instances of pressure ulcers, falls, medicine errors, staffing levels, patient care experience and the friends and family test scores. Dashboards were displayed on the entrance to most wards. This information was collected but not always used to inform actions which could improve the service, which is highlighted in their high number of falls and medicine management errors.

Patient identifiable information was mostly well managed. Records that contained patient identifiable information was correctly stored. However, on two occasions we did see handover sheets left out in the ward corridor on ward 10 during a night visit.

**Engagement**

The trust engaged generally well with patients and staff to plan and manage appropriate services effectively.

Staff on the wards were generally positive about engagement. Nursing staff told us that the wards had monthly or bi-monthly team meetings in which they could raise and discuss any issues that concerned them. However, one staff member felt completely excluded from all ward decisions at meetings and huddles. They were also afraid to raise any issues externally as they felt there would either be no improvement or they would lose their job.

Staff engaged with patients and involved them in ward development. Staff gave us examples where patients and relatives of patients, particularly ones who had been involved in incidents and complaints, were involved and consulted when it came to service development on an ongoing basis.

Staff told us that they had seen new information displayed around the hospital with changes to personnel and names of executives on them. Most staff we spoke to said that they had not met the CEO (Chief executive officer). However, they received updates through e-mails and felt well informed.

**Learning, continuous improvement and innovation**
The trust had some plans in place to improve services.

Trust wide training about people living with dementia and managing their stay in hospital had been introduced. These were known as compassionate masterclasses and staff could improve knowledge and make pledges to work differently, when dealing with someone having dementia or similar conditions. This included simple pledges such as, asking people their name, asking how they are and understanding what is important to individual patients.

Divisional leads were introducing skype calls to improve the way time was managed around trust wide meetings. This initiative was suggested to reduce the travel to and from different sites, particularly with the increase in geographical footprint since the acquisition.
Facts and data about this service

Surgical services at the University Hospitals Birmingham NHS Foundation Trust are provided at the Queen Elizabeth hospital, Good Hope hospital, Heartlands hospital and Solihull hospital. This evidence appendix focuses on surgical services provided at Good Hope hospital. Surgical services at the other sites are reported in separate evidence appendices. However, as the management team at Heartlands hospital, also have responsibility for services at Good Hope hospital and Solihull hospital, and some staff also provided care and treatment at these sites, there are inevitably some elements of the report that are the same across each of the three sites.

Good Hope Hospital is part of the University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust. This trust underwent an acquisition in April 2018, therefore all national datasets contained within this appendix relate to this period onwards.

Good Hope Hospital serves North Birmingham, Sutton Coldfield and a large part of south East Staffordshire including Burnt wood, Lichfield and Tamworth. The catchment population is about 450,000.

Good Hope Hospital provides a range of emergency and elective surgery for the local population. This includes inpatient and day case surgery and, in addition to general surgery, specialties include, trauma and orthopaedics, urology, and ophthalmology services.

There are four surgical wards, ward 14, 15, 16 and 17. Ward 17 is the Surgical Assessment Unit (SAU). There is a day care unit and eight operating theatres on the site.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we have only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

A site breakdown can be found below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>Ward 14</td>
<td>Elective orthopaedics and trauma</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 15</td>
<td>Elective orthopaedics and trauma</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 16</td>
<td>Elective/emergency colorectal surgery</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 17 SAU</td>
<td>Surgery assessment unit/general surgery</td>
<td>21</td>
</tr>
<tr>
<td>Ward 4</td>
<td>Elective/emergency thoracic and vascular surgery</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------</td>
<td>----</td>
<td></td>
</tr>
<tr>
<td>Ward 5</td>
<td>Elective/emergency ENT/general surgery</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Ward 8</td>
<td>Acute trauma and rehabilitation</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Ward 9</td>
<td>Acute trauma and rehabilitation</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Ward 10</td>
<td>Elective/emergency urology and urology treatment centre</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Ward 11</td>
<td>Surgery assessment unit/general surgery</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Ward 12</td>
<td>Elective/emergency colorectal surgery</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td></td>
<td>108</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admissions lounge</th>
<th>Elective surgical admissions</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory care services</td>
<td>Day case and short stay surgery</td>
<td>81 trolleys</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Theatres</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Ward 305</td>
<td>General surgery/vascular surgery</td>
<td>36</td>
</tr>
<tr>
<td>Ward 306</td>
<td>Cardiac surgery</td>
<td>36</td>
</tr>
<tr>
<td>Ward 409</td>
<td>Neurosurgery</td>
<td>36</td>
</tr>
<tr>
<td>Ward 410</td>
<td>Trauma</td>
<td>36</td>
</tr>
<tr>
<td>Ward 412</td>
<td>Trauma</td>
<td>36</td>
</tr>
<tr>
<td>Ward 620</td>
<td>Surgical assessment unit</td>
<td>36</td>
</tr>
<tr>
<td>Ward 624</td>
<td>Urology/ENT/MaxFax/plastics</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td></td>
<td>207</td>
</tr>
</tbody>
</table>

| Ward 14           | Elective urology/general surgery and urology daycase/treatment centre | 14 |
| Ward 15           | Elective orthopaedics        | 33 |
| **Total beds**    |                               | 47 |

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provides two nationally commissioned transplant programmes:
- Heart / lung
- Liver

Birmingham Heartlands Hospital hosts the regional thoracic surgery service and is home to the vascular hybrid operating theatre.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust had 46,812 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 14,392 (30.7%), 23,026 (49.2%) were day case, and the remaining 9,394 (20.1%) were elective.

Heart of England NHS Foundation Trust
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust had 59,370 surgical admissions from April 2017 to March 2018. Emergency admissions accounted for 19,116 (32.2%), 33,370 (56.2%) were day case, and the remaining 6,884 (11.6%) were elective.

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all nursing staff had completed it.

While on most courses, staff met the trust’s target or were close, resuscitation training was almost 13% below target.

Mandatory training completion rates

Good Hope Hospital

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>181</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>181</td>
</tr>
<tr>
<td>Medicsines management</td>
<td>180</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>178</td>
</tr>
<tr>
<td>Waste management</td>
<td>176</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>170</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>165</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>164</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>157</td>
</tr>
<tr>
<td>Information governance</td>
<td>155</td>
</tr>
<tr>
<td>Fire safety</td>
<td>146</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>140</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall training compliance rate of 91.4% for qualified nursing staff. The trust’s 90% completion target was met for eight of the 12 mandatory training modules for which qualified nursing staff were eligible. The resuscitation - clinical module had the lowest completion rate, at 77.3%.

The trust had an action plan in place to help to improve resuscitation training figures and expected compliance rates for resuscitation training was to be at 100% by 29 November 2018.

The service provided mandatory training in key skills to all staff. However, not all medical staff had completed it.
Although the service had an action plan to help medical staff improve in the seven areas where they were not meeting training targets, it had no specific action plans or trajectory to improve completion of resuscitation training. The trust must improve resuscitation training for medical staff.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in surgery at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>100</td>
<td>101</td>
<td>99.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>98</td>
<td>101</td>
<td>97.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>98</td>
<td>101</td>
<td>97.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>96</td>
<td>101</td>
<td>95.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>92</td>
<td>101</td>
<td>91.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>86</td>
<td>101</td>
<td>85.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>83</td>
<td>101</td>
<td>82.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>75</td>
<td>100</td>
<td>75.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>75</td>
<td>101</td>
<td>74.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>73</td>
<td>101</td>
<td>72.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Waste management</td>
<td>65</td>
<td>101</td>
<td>64.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>64</td>
<td>101</td>
<td>63.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall training compliance rate of 83.0% for medical staff. The trust’s 90% completion target was met for five of the 12 mandatory training modules for which medical staff were eligible. The conflict resolution module had the lowest completion rate, at 63.4%.

The mandatory training was comprehensive and met the needs of patients and staff. It included updates in manual handling, infection control, safeguarding, fire safety and health and safety. It was designed to keep patients and staff safe, as well as making sure staff knew how to use systems within the trust.

Managers in wards and theatres monitored staff training and showed us records of this. Staff received email reminders when their mandatory training was due.

Staff training targets were displayed and on one ward staff were named on the ‘Wall of Shame’ if they were not achieving training targets. Staff took this in good spirit and it had the effect of creating completion amongst the staff.

Managers supported staff to help them achieve training targets. Staff were allocated time to complete their mandatory training and had access to computers on the wards and in theatres. Staff could also access the computer system from home for training. The trust was in the process of appointing an educational nurse for the department to help support staff with training needs.
The training was of a high standard combining online and face-to-face modules. Staff could describe what they had learned from the training. The online modules were interactive and engaging and staff said these were interesting to complete.

**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.

There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safe using local safeguarding procedures whenever necessary.

**Staff had received up to date training in all safety systems, processes and practices.**

Safeguarding training updates formed part of the mandatory training key skills and ward managers monitored this training.

Trust training included ‘PREVENT’ awareness. ‘PREVENT’ is one of the arms of the government’s anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation.

Awareness of female genital mutilation (FGM) was included in safeguarding training and staff had knowledge of the issue. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

### Safeguarding training completion rates

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Good Hope Hospital is shown below:

| Name of course | April 2017 to March 2018 | | | | |
|----------------|--------------------------|---|---|---|
|                | Number of staff trained | Number of eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Safeguarding level 1 children and adults | 181 | 182 | 99.5% | 90.0% | Yes |
| Safeguarding level 2 children and adults/ DoLs and mental capacity | 179 | 181 | 98.9% | 90.0% | Yes |

In surgery, the hospital had an overall safeguarding training compliance rate of 99.2% for qualified nursing staff. The trust's 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in surgery at Good Hope Hospital is shown below:

| Name of course | April 2017 to March 2018 | | | | |
|----------------|--------------------------|---|---|---|
|                | Number of staff trained | Number of eligible staff | Completion rate | Trust target | Met (Yes/No) |
| Safeguarding level 1 children and adults | 95 | 101 | 94.1% | 90.0% | Yes |
Safeguarding level 2
children and adults/ DoLs
and mental capacity

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>101</td>
<td>87.1%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall safeguarding training compliance rate of 90.6% for medical staff. The trust’s 90% completion target was met for one of the two safeguarding training modules for which medical staff were eligible.

The trust **should** ensure that the completion rate for medical staff safeguarding training level 2 children is improved to reach the 90% target rate.

**Staff had access to information about how to raise safeguarding concerns and make referrals.**

There was information displayed on the wards and in theatres for staff guidance on how to raise safeguarding alerts including contact telephone numbers for the local authority safeguarding teams.

The trust had a safeguarding lead staff member for staff information and guidance.

Staff had access to the ‘Adult Safeguarding’ folder on ward containing information about safeguarding.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well.** The Trust had systems in place for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The wards, operating theatres and clinics we inspected were clean and well-presented and waste was managed appropriately.

In operating theatres we observed that pre-operative staff (who were scrubbing in) were thorough with their scrubbing in techniques. There was careful use of the sterile field and use of sterile theatre packs.

There was a team of domestic and housekeeping staff who had a programme of cleaning for the different areas. The housekeeping and domestic staff were allocated to their own wards and said they were ‘very proud’ of the wards/departments they worked in.

**Staff used control measures to prevent the spread of infection.**

Arrangements were in place to isolate people awaiting elective surgery pre-operatively from people requiring emergency surgery.

Equipment which had been cleaned had ‘I am clean’ stickers on displaying the date they were cleaned.

Disposable curtains were used around trolleys and beds. For example, in the recovery room in theatre we saw these had dates on when they had been or were due to be changed.

The nurse in the recovery room explained how each morning cleaning and checking of equipment was carried out and we saw that cleaning records were maintained and were up to date. The nurse was in the process of cleaning the intra venous infusion (IVI) stands as we arrived.

Hand gel was readily available at the end of all beds and handwashing facilities were available in all clinical areas. During the inspection we observed good compliance with hand hygiene...
procedures and the hands ‘bare below the elbows’ policy. We observed nursing staff using hand sanitiser between patients and before finishing their duties.

Personal protective clothing and equipment (PPE) were available within clinical areas and we observed staff using them when providing care. Staff in the operating theatres wore the correct attire with hats covering their hair, appropriate theatre footwear and face masks. Staff followed the surgical hand asepsis technique and donned gowns and gloves using the sterile technique as per NICE CG74 guidance.

**Staff received up to date training in infection control.**

Infection control training formed part of the mandatory staff training programme and the trust’s target of 90% completion rate had been met by nursing and medical staff.

**Wards audited infection rates and action plans were in place to make improvements where required.**

Audits of infection control were carried out monthly including hand hygiene in every department and on every ward and these showed good results with targets being met. If targets were not met the infection control nurses would work with the ward managers to make improvements.

This had helped to improve infection rates for example, on ward 16 we saw rates for emergency screening of Methicillin-resistant Staphylococcus aureus (MRSA) had improved from 86% in July 2018 to 93% in October 2018. Elective surgery MRSA screening was at 100%. MRSA is a type of bacteria that's resistant to several widely used antibiotics.

The hospitals in the former Heart of England NHS trust which included Good Hope hospital, submitted data for the national surgical site infection (SSI) audits for 2016/2017 for repair of fractured neck of femur and data showed the percentage of patients developing an infection was in line with other trusts. They did not submit data for the SSI surveillance programme for hip or knee prosthesis. However, they sent us a copy of work they had been undertaking to investigate and improve surgical site infections in orthopaedic surgery. The Trust also had an extended scope practitioner referral pathway for prosthetic joint infection. In addition, the colorectal surgical speciality completed a local surgical site infection audit. The results of this are reported under patient outcomes in this evidence appendix.

A surgeon was proud to tell us that surgical site infection rates were monitored and had improved. Results for surgical site infection rates had improved from 10-15% in 2016 to 2% in 2018.

Wards audited infection rates and action plans were in place to make improvements where required. This had helped to improve infection rates for example, on ward 16 we saw rates for emergency screening of Methicillin-resistant Staphylococcus aureus (MRSA) had improved from 86% in July 2018 to 93% in October 2018. Elective surgery MRSA screening was at 100%. MRSA is a type of bacteria that's resistant to several widely used antibiotics.

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A surgeon was proud to tell us that surgical site infection rates were monitored and had improved. Results for surgical site infection rates had improved from 10-15% in 2016 to 2% in 2018.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.
The surgical wards and the day procedures unit had secure entry systems to enable staff to monitor people entering and leaving the wards. Visitors gained access by ringing a bell by the entrance to the ward.

The wards were arranged in six bedded bays, with a small number of single rooms.

Piped oxygen and suction equipment was available at each bed space, as well as call bells for patients and for emergency use.

There were sufficient toilet and bathroom facilities which were designated as single sex in line with Department of Health guidance and adapted for the safety of patients with a disability.

**Equipment had been serviced and checked as required and the trust had service contracts in place with relevant companies.**

The trust had contracts in place with external companies to service and maintain equipment throughout the hospital.

We looked at 15 pieces of equipment and saw that these had been serviced and tested as required and there were labels attached to evidence this. This included anaesthetic and resuscitation equipment.

**Electrical equipment in the operating theatres showed evidence of regular servicing and maintenance.**

Daily checks were carried out on equipment where required. For example we saw checks had been carried out on the emergency trolleys (crash/defibrillator and difficult intubation trolley) and the paediatric airway trolley. All disposable items such as defibrillator pads, ECG electrodes, ambu bag, masks, airways, laryngoscope blades, and the emergency drugs case were all present as per the checklist and all well within expiry dates.

Anaesthetic machines, anaesthetic ventilators, syringe pumps/drivers, patient monitors seen on the inspection days were all in date and the last date of services or calibration was in place on the labels on each piece of equipment.

Equipment in theatres had specific parking areas which helped keep areas tidy and clutter free and staff knew exactly where to find equipment. We saw tidy well organised store rooms on wards and in theatres. For example, in theatres there was a good system for instrument set storage in library style racking.

Equipment on wards was stored along corridor areas due to lack of storage space. However, corridors were wide enough so, although this was not ideal, it did not pose a fire or health and safety risk.

A contract was in place with an external supplier for the sterilisation of theatre instruments and trays. These were mostly processed in a timely manner. Band six theatre nurses were responsible for checking and arranging the repair or replacement of instruments as required.

**Regulations falling under Control Of Substances Hazardous to Health (COSHH) were met.**

Substances were stored away and locked as required under COSSH regulations. Staff received training in COSHH.

**Equipment for patients could be obtained when required and without delay but bariatric equipment had to be ordered.**
A ward manager explained how they had direct access to the company who provided equipment and they could order what was needed and this was usually delivered within 2 hours. We did not see any use of bariatric equipment and managers said these could be obtained when required but had to be ordered separately.

Assessing and responding to patient risk

Risks to patients were assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenges.

Arrangements were in place for patients sustaining a major haemorrhage and guidelines for staff were contained in the trust’s ‘Massive bleed protocol’.

Patients had a comprehensive pre-operative assessment of their needs and any risks to their health and safety were identified and care plans put into place where required. A standard proforma was used by staff, to ensure a consistent approach was taken.

The service used the American Society of Anaesthetists (ASA) classification system to grade a patient’s level of risk and plan the patients care accordingly. Patients with a higher level of risk were directed to other trust sites as necessary to maintain patient safety. When additional risks were identified, staff in the pre-assessment clinic referred the patient to an anaesthetist for further review.

Patients who were at risk of developing blood clots were screened on admission and relevant precautions taken.

NICE guidance (NG89) published in March 2018 states that all surgical and trauma patients should be assessed to identify the risk of VTE (venous thrombo-embolism or blood clots) as soon as possible after admission to hospital.

We looked at four VTE assessments and saw these had followed the correct pathway for patients who had been identified as being at risk of developing blood clots. The patients were prescribed anticoagulant (blood thinning) therapy following surgery.

In the operating theatre we saw the use of sequential compression devices. These are electronically operated intermittent pressure cuffs that fit around the patients’ calves to help avoid the development of blood clots.

Patients who were at risk of falls were assessed and safety precautions taken.

High/low beds and crash mats were provided where appropriate. If a patient had a fall in hospital then one to one care was provided.

On some of the wards patients who were at risk of falls were nursed in the same bay and supervised by a staff member at all times.

Patients who were at risk of skin damage/developing pressure ulcers were assessed and care plans put into place to help alleviate pressure and avoid skin damage.

Skin bundles were used. This was a systematic approach to reduce the incidence of pressure ulcers.

Special equipment and mattresses were used where indicated. For example, we saw in theatres that a patient was placed onto a specialist pressure relieving mattress to help avoid skin damage as the patient was being operated on for several hours.

On ward 16 we saw a ‘repositioning regime’ chart displayed by the nurses’ station where staff could easily identify when patients had been repositioned and when they required this. This had
been developed as a result of a serious incident. Health care assistants had taken ownership of this and we saw patients had all been repositioned as required.

**Clinical observations were carried out on patients at appropriate intervals to ensure patient's conditions were monitored safely.**

Staff adhered to the World Health Organisation (WHO) safety checks and these were monitored and audited to ensure completion. In operating theatres we observed staff carrying out the WHO checklist. The WHO checklist was electronic and staff used an electronic tablet at the side of the patient to complete checks. The trust audit for September 2018 showed 98.6% compliance.

**Staff completed the Modified Early Warning System (MEWS) and sepsis charts appropriately.**

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. The trust had a sepsis protocol and used the national ‘Sepsis 6’ pathway to identify and treat sepsis. Managers told us sepsis training was included in the training provided on MEWS. Data provided by the trust (DR191) showed sepsis training was provided as part of the new staff induction training in 2017 and 2018.

Staff we spoke with were aware of the importance of identifying possible sepsis and providing interventions in a timely manner.

One of the medical staff (anaesthetist) was involved in training staff in sepsis. Staff could contact them for advice and support if they needed this.

We checked the observation charts for six patients and found the MEWS score was recorded with every set of observations. In instances when the score had increased, staff had taken action to alert the doctors or critical care outreach team to the issue. Notes written by medical staff and the critical care outreach team indicated the patient was reviewed in a timely manner following escalation.

**Staff adhered to health and safety operating procedures.**

For example, during surgery the electric wires of machines were taped to the floor using safety electrical tape to make staff aware of the trip hazard.

We observed correct manual handling techniques being used in wards and with transfer of patients from trolleys and beds and on to the operating table.

Major incidents were part of initial mandatory training e-learning and managers took part in face to face training to lead in aspects of the plans.

The senior management team for surgery told us they were in the process of developing Local Safety Standards for Invasive Procedures (LocSSIPs) in line with national guidance. The minutes of some of the specialty governance meetings showed they were being developed and discussed. In addition the trust provided us with a copy of some of the LocSSIPs following the inspection. However, staff in theatres were unaware of the initiative and of the progress being made.

**Nurse staffing**

The surgical department were actively trying to recruit band five nurses to help fill posts across the wards and theatres. However, managers ensured that in the interim there were enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Nurse vacancies were identified as a risk on the divisional risk register and a committee was overseeing recruitment initiatives.
The trust used the national safer nursing care tool to review and set their nurse staffing levels. Staff told us the tool was used annually and when there was a change in the ward which might influence staffing requirement. Senior sisters we spoke with felt their planned staffing levels reflected the staffing requirements and said they had received uplifts in staffing in the past when the tool and their professional judgement indicated additional staff were required.

Staffing levels and skill mix were planned, implemented and reviewed to help keep patients safe at all times. However, there were vacancies for 11 band five nurses across the surgical division including theatres. Prior to the inspection we had received concerns about shortage of nurses on night duty. Staff told us that staffing was a problem for example on ward 15, there should have been three nurses for 29 patients and most nights there were only two nurses on duty. The trust told us they were actively attempting to recruit band five nurses.

The trust must ensure that enough staff are on duty to meet the needs of patients

Where there were staff shortages these were responded to quickly and adequately by staff taking on extra shifts and bank and agency use.

Managers told us staff were given the opportunity to take on extra shifts. Where shifts could not be covered by permanent staff, managers tended to book the same bank and agency staff who were familiar with the working environment on wards and in the operating theatres to ensure safety and continuity.

In operating theatres, staff told us they had previously had vacancies for nurses and operating department practitioners (ODPs); however, the vacancies were now filled albeit they were waiting for some newly recruited staff to commence work. The impact of the previous vacancies had been mitigated by the use of regular bank and agency staff. As a result, they were meeting the standards for staffing levels in theatres published by the Association for Peri-operative Practice (AfPP). We were told that the theatre staffing levels were under review at the time of the inspection, as there was no allowance within the staffing budget for absence due to sickness or training.

Planned and actual nurse staffing levels were displayed on a board within each ward. We reviewed these during the inspection and saw that in most instances the planned levels were met.

There were effective handovers at shift changes to ensure that staff could manage acuity of patients and risks.

We observed a nursing handover, a doctors’ handover and a theatre staff handover. These provided clear, up to date and vital information about patients, their wellbeing and their needs from one set of staff to the next. This ensured safe, effective and consistent care and treatment.

The trust had reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in surgery.

The overall fill rate for qualified nursing staff dropped from 87.5% in March 2018 to 85.6% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site</td>
<td>Agency</td>
<td>Bank</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>2,468</td>
<td>34,240</td>
</tr>
<tr>
<td>Other sites</td>
<td>3,373</td>
<td>5,775</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Total staff tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 15.5% for nursing staff in surgery. This was higher than the trust target of 5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:

- Good Hope Hospital: 17.8%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 8.7% for qualified nursing staff in surgery. This is above the trust target of 8.5% for Good Hope Hospital.

A breakdown by site is below:

- Good Hope Hospital: 12.9%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From April 2017 to March 2018, the trust reported a sickness rate of 5.0% for qualified nursing staff in surgery at Good Hope Hospital. This is above the trust targets of 3.6%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From April 2017 to March 2018 the trust reported 5,841 shifts were filled by agency staff, 40,015 by bank staff and 23,539 shifts were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>2,468</td>
<td>34,240</td>
<td>19,211</td>
</tr>
<tr>
<td>Other sites</td>
<td>3,373</td>
<td>5,775</td>
<td>4,328</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**
Good Hope Hospital had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm.

The trust had reported their staffing numbers below for March 2018 and June 2018 for medical staff in surgery.

The overall fill rate for medical staff dropped from 94.9% in March 2018 to 92.4% in June 2018. Solihull Hospital has a particularly low rate, with only one member of staff in post out of a planned five in June 2018.

Medical staff for surgery consisted of eight Consultant Surgeons and six Senior House Officers (SHO) and junior doctors who were ward based.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
<td>Fill Rate</td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
<td>Fill Rate</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>586.0</td>
<td>555.7</td>
<td>105.5%</td>
<td>580.4</td>
<td>562.8</td>
<td>103.1%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>254.9</td>
<td>334.8</td>
<td>76.1%</td>
<td>256.0</td>
<td>350.7</td>
<td>73.0%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>102.0</td>
<td>100.0</td>
<td>102.1%</td>
<td>100.0</td>
<td>95.8</td>
<td>104.5%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>1.0</td>
<td>4.0</td>
<td>25.0%</td>
<td>1.0</td>
<td>5.0</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Queen Elizabeth Hospital and Good Hope Hospital were over staffed in both March and June 2018. In June 2018, Queen Elizabeth Hospital was over staffed with 17.6 WTE higher than planned and Good Hope Hospital was over staffed with 4.2 WTE higher than planned.

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 15.5% for nursing staff in surgery. This was higher than the trust target of 5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:

• Good Hope Hospital: 17.8%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 7.0% for medical staff in surgery. This is below the trust target of 8.5%.

Good Hope Hospital turnover rate was high at: 15.5%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 1.1% for medical staff in surgery. This is below the trust targets of 4.0% for Good Hope Hospital and its community locations.

A breakdown by site is below:

- Good Hope Hospital: 0.6%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Locum and agency staff usage

From April 2017 to March 2018 the trust reported that 10,444 shifts were filled by agency medical staff, 8,034 by locum medical staff and that 1,292 were left unfilled.

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>936</td>
<td>2,425</td>
<td>105</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In May 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Staffing skill mix for the whole time equivalent staff working at University Hospitals Birmingham NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>53%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>10%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care.
We looked at records of 22 patients including medical records, patient care records and records of patient care and treatment in the operating theatres.

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.

Records clearly reflected the patient journey and included reviews and input from the multidisciplinary team including doctors, nurses, surgeons, physiotherapists, dieticians, occupational therapists and other health care professional where appropriate.

A ‘Surgical Pathway’ in-patient document was completed. This started on the day care unit, and was further assessed in theatres. The MEWS score and pre-operative checklist were completed. The document had bar codes added for tracking of disposable instruments used. Written captures of cannulas (VIP) catheter documents were signed. There was a recovery and hand over page, observational charts and take home medicines (TTOs).

**Medicines**

The service prescribed, administered, recorded and stored medicines as required but protocols in respect of allergies to medicines were not always followed.

We observed a nurse administering medication who knew that a patient was allergic to penicillin, as they remembered the patient from a previous visit to hospital. However, the patient’s allergy to the medicine was not recorded on the electronic patient record and the patient was not wearing a red band (as per allergy protocol). This meant that the patient could be in danger of receiving this medicine from other nurses who did not know about the allergy.

The department had previously had an incident where a nurse had given penicillin to a patient who was allergic to it. The nurse had received further training following the incident.

The trust **must** ensure that medicines are administered safely.

**Records of medication were completed for each patient.**

We looked at 15 medicine administration records. These were completed and clearly reflected that medicines had been administered as per prescription. Where patients were on antibiotics clinical indication, dose and duration were completed.

Staff had also signed records when medication had been omitted and documented the reason for this.

**Medicines including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were stored securely and checked regularly in both the wards and operating theatres.**

We checked the records on a ward and in the operating theatres in respect of eight controlled medicines and saw that these medicines were stored appropriately. Two nurses checked and signed for the medicines in from pharmacy and two nurses checked and signed for the medicines each time they were administered to patients. Two nurses also checked and signed when medicines were disposed of. Clear records of management of controlled medicines were maintained. Staff told us they had good support from the pharmacy team.

**Medicines were stored appropriately.**

Refrigerator and room temperatures were checked daily by staff to ensure medicines were stored within the recommended safe temperature zones and records were kept where staff had signed.
Intravenous fluids and were stored in locked areas.

**Special precautions were taken in relation to medicine safety.**

We observed the use of chemotherapy during HIPEC surgery. There was a Cytotoxic Safety Standard Operating procedure (SOP) in place which was strictly followed by the operating surgeon and all staff involved. The medicine had been transported from another hospital and all relevant precautions had been taken to ensure safety measures were followed.

The theatre sister was very familiar with the Cytotoxic SOP and had adapted it in relation to the handling of instruments and drapes.

**Incidents**

**The service managed patient safety incidents well.**

All clinical incidents, however small, were taken seriously by the trust and any issues or discrepancies raised during the execution of the services were reported to the Clinical Governance Manager.

**Staff recognised incidents and reported them appropriately.**

All incidents were logged via the Insight system and managed by the clinical governance team. Clinical discrepancy records were crucial to the effective monitoring and service revision and staff had a responsibility to ensure incident records were accurate and comprehensive.

**Managers investigated incidents and shared lessons learned with the whole team and the wider service.**

Lessons were learned and communicated throughout the trust to support improvement in other areas where relevant. We saw where incidents were discussed during ward meetings and that a newsletter was sent to update staff about cascade information from learning.

**When things went wrong, staff apologised and gave patients honest information and suitable support.**

When something went wrong there was an appropriate thorough review or investigation that involved all relevant staff, partner organisations and patients. This included being open and honest with the patient and their families.

**Openness and transparency about safety was encouraged.**

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses on the electronic incident reporting system and were supported to do so.

**Improvements to safety were made and the resulting changes monitored.**

As a result of a serious incident in respect of skin damage, we saw where learning had taken place and a 'reposition chart' had been commenced which had helped staff monitor how often patients had their pressure relief/positions changed.

We saw that a policy was amended following an incident involving paediatric services to ensure that patients who required surgery did not experience unnecessary delays.

There was a serious incident in theatres where a patient had sustained compartment syndrome. This was still being investigated at time of inspection. Compartment syndrome is a condition in which increased pressure within one of the body's compartments results in insufficient blood supply to tissue within that space.
Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From August 2017 to July 2018, the trust reported four incidents classified as never events for surgery:

Retained foreign object in April 2018 at Good Hope Hospital

(Source: Strategic Executive Information System (STEIS))

Following this Never Event the wording of the policy had been changed to become standardised with the Queen Elizabeth hospital. The surgeon had been actively engaged with the patient and their family and had completed the duty of candour. Observational audits for swab checks were now carried out.

We also saw swab collection bags being used in theatre with individual swab pockets which meant it was easier to see and count swabs.

Staff thought feedback and learning from serious incidents and never events was good and de-briefs took place where required.

Outcomes, learning and action plans were displayed in staff areas such as coffee rooms.

A medical officer involved in the Never Event recalled the discussion about the never event and the briefing and learning from this.

Breakdown of serious incidents reported to STEIS

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 33 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England occurring from August 2017 to July 2018.
The breakdown by type of incident reported were:

- Surgical/invasive procedure incident with 11 (33.3% of total incidents)
- Slips/trips/falls with six (18.2% of total incidents)
- Pressure ulcer with five (15.2% of total incidents)
- HCAI/Infection control incident with five (15.2% of total incidents)
- Diagnostic incident including delay with two (6.1% of total incidents)
- Medication incident with two (6.1% of total incidents)
- Sub-optimal care of the deteriorating patient with one (3.0% of total incidents)
- Treatment delay with one (3.0% of total incidents)

Site specific information can be found below:

- Good Hope Hospital (April to July 2018): two incidents

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2017 to March 2018.
The breakdown by type of incident reported were:

- Pressure ulcer with eight (34.8% of total incidents)
- Slips/trips/falls with six (26.1% of total incidents)
- Surgical/invasive procedure incident with three (13.0% of total incidents)
- Sub-optimal care of the deteriorating patient with two (8.7% of total incidents)
- Diagnostic incident including delay with two (8.7% of total incidents)
- HCAI/infection control incident with two (8.7% of total incidents)

Site specific information can be found below:
- Good Hope Hospital: eight incidents

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.

Data collection took place one day each month – a suggested date for data collection was given but wards could change this. Data had to be submitted within 10 days of suggested data collection dates.

We saw that the safety thermometer was displayed in theatres but not consistently displayed on wards. The trust should ensure that up to date safety thermometer information is clearly displayed.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.
Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services as all incidents were reported under the core service ‘Other’.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported 50 new pressure ulcers, eight falls with harm and two new catheter urinary tract infections from August 2017 to August 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Heart of England NHS Foundation Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Please note that this includes data for April to June 2018 which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.

(Source: NHS Digital)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

All policies and procedures for surgery were being reviewed and where possible aligned with the Queen Elizabeth hospital to achieve consistency across the trust, following the acquisition. The senior management team told us specialties were taking steps towards integration and the review of pathways and procedures formed part of this.

The trust reported that all new NICE guidelines were identified at the end of each month and were sent to clinical leads for each specialty for implementation

The trust provided evidence that they completed audits to compare the care and treatment provided in each of the surgical specialties and whether this complied with NICE guidance for the procedures or other published data. For example, trauma and orthopaedics compared their results for hip resurfacing against published data and monitored the national joint registry results. They found their results compared favourably to other published studies and the national joint registry.

There was a programme of audit for each surgical specialty and the trust provided us with a sample of the audits completed and learning gained from them. As most of the surgeons at Good Hope hospital, also worked at Heartlands hospital and/or Solihull hospital, the results were sometimes specific to one hospital, when surgery was focused on one of the sites, and in other cases amalgamated results from more than one site. However, it was apparent from the data provided, that each specialty audited and assessed their practice on an ongoing basis.

Guidelines were closely adhered to by staff on wards and in operating theatres.

We saw the following guidelines were in place, up to date and available for staff to refer to:

- The Royal College of Surgeons (RCS) Standards for Unscheduled Surgical Care
- NHS Institute for Innovation and Improvement (Enhanced Recovery programme)
- RCS Good Surgical Practice (September 2014)
- AAGBI (Association of Anaesthetists Guidelines for Great Britain and Ireland)
- The National Institute for Health and Care Excellence (NICE) QS66 Statement 2 – governing the use of intravenous therapy
- NICE QS3 Statement 5 – governing patients at risk of VTE
- NICE QS90 – governing urinary tract infections in adults
- BADS - British Association of Day Surgery
- National Safety Standards for invasive procedures (NatSSIPs).

However, local safety standards for invasive procedures (LocSSIPs) were not fully in place and were in the process of being developed although relevant standard operating policies (SOP) and policies were in place and followed by staff.

Nutrition and hydration
Staff gave patients enough food and drink to meet their needs and improve their health and patients’ nutritional needs were assessed.

Staff used a nationally recognised assessment tool and, where indicated, plans of care were put into place to help meet patients’ nutritional and hydration needs. These were monitored and reviewed regularly.

**Patients fluid and food intake were monitored where required.**

Where patients needed their fluid intake and output monitoring they were placed on a fluid balance chart, where intake and output were monitored over each 24-hour period.

Where staff needed to ‘keep an eye’ on how often patients were drinking but did not need to measure fluid intake and output the wards used a ‘hydration chart’.

**Patients had access to fluids.** We saw where drinks and jugs of fluids were left within patient’s reach and replaced regularly. Patients were offered regular hot drinks throughout the day.

**Patients were helped to eat and drink.** Patients who required help to eat their meals were served their meals on a red tray so that staff knew they required assistance. We saw staff helping patients to eat and drink.

**The service made adjustments for patients’ religious, cultural and other preferences.**

Special diets were catered for. We saw patients receiving special diets such as diabetic diets and soft diets.

Menus contained choices for patients for each meal.

A visitor told us that it had taken ‘a while’ to provide a gluten free diet for their relative but that now ‘it was sorted’ it was better.

**Staff had access to a dietician.** Where patients needed professional advice and support with nutrition staff made a referral to a dietician. Staff told us this did not take long, the ward manager showed us how referrals were made electronically on the computer system. Patients were prescribed nutritional supplements when required.

**Patients were fasted prior to surgery.** Prior to surgery patients were kept ‘nil by mouth’ and fasted in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Patients who were admitted to hospital on the day of surgery and day surgery patients were provided with instructions about the need to fast before their surgery and the time when they could have their last food and drink. When the order of the operating list was changed, the anaesthetist contacted the ward to let the staff know the patient could have additional drinks, where applicable.

**Post-operative nausea and vomiting was monitored.** Patients were usually given anti-sickness medicine (anti emetic) in theatre and again on the ward if they needed it.

**Pain relief**

**Patients had their pain control needs assessed and effectively managed.**

Staff used a pain assessment tool to assess the severity of pain for each patient. For patients who were unable to communicate verbally staff spoke with the family and/or carer to determine how patients expressed their pain. Staff told us this could often be via facial expressions or other behaviours.

Following surgery some patients had a Patient Controlled Analgesia (PCA) intravenous infusion in place and were instructed by staff how to use this. Other patients were offered other analgesia.

Patients told us that their pain was managed and they received their pain relief medicines on time.
The trust employed pain control nurses to support staff to manage patient’s needs.
Palliative care nurses visited wards where patients who were receiving end of life care needed help controlling pain. The palliative care nurses supported nursing staff on the wards with how best to manage the patient’s pain control.

Managers monitored the effectiveness of care and treatment and used the findings to improve them.
They compared local results with those of other services to learn from them. Performance in national outcome audits was mostly positive with good outcomes in the national vascular registry, the national bowel cancer audits and the national joint registry

Relative risk of readmission

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Good Hope Hospital – elective admissions

From May 2017 to April 2018, patients at Good Hope Hospital had a higher than expected risk of readmission for elective surgical admissions compared to the England average.

Patients in general surgery had a lower than expected risk of readmission for elective admissions.

Patients in ophthalmology had a higher than expected risk of readmission for elective admissions.

Patients in urology had a similar to expected risk of readmission for elective admissions.

Elective Admissions - Good Hope Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Good Hope Hospital - non-elective admissions

From May 2017 to April 2018, patients at Good Hope Hospital had a higher than expected risk of readmission for non-elective surgical admissions compared to the England average.

Patients in general surgery and trauma and orthopaedics had a higher than expected risk of readmission for non-elective admissions.
Please note: There were readmissions for plastic surgery which were included in the total figures but not in the specialty breakdown due to the small number involved.

Non-Elective Admissions - Good Hope Hospital

![Bar chart showing non-elective admissions for Good Hope Hospital]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top two specialties for specific site based on count of activity.

National Hip Fracture Database

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 6.5% which was within the expected range. The 2016 figure was 5.1%.

The proportion of patients having surgery on the day of or day after admission was 69.5%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 65.1%.

The perioperative medical assessment rate was 96.5%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 87.6%.

The proportion of patients not developing pressure ulcers was 99.8%, which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 99.3%.

The length of stay was 24.2 days, which falls within the middle 50% of trusts. The 2016 figure was 24.0 days.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Good Hope Hospital

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 8.5% which was within the expected range. The 2016 figure was 11.4%.

The proportion of patients having surgery on the day of or day after admission was 47.9%, which
failed to meet the national standard of 85%. This was within the bottom 25% of trusts. The 2016 figure was 57.9%.

The perioperative medical assessment rate was 96.6%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 80.8%.

The proportion of patients not developing pressure ulcers was 89.6%, which failed to meet the national standard of 100%. This was within the bottom 25% of trusts. The 2016 figure was 92.0%.

The length of stay was 18.8 days, which falls within the middle 50% of trusts. The 2016 figure was 17.6 days.

(Source: National Hip Fracture Database 2017)

Bowel Cancer Audit

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2017 Bowel Cancer Audit, the number of patients undergoing a major resection with a post-operative length of stay greater than five days was not reported. The 2016 figure was 71.3%.

The risk-adjusted 90-day post-operative mortality rate was 0.0% which was within the expected range. The 2016 figure was 8.6%.

The risk-adjusted 2-year post-operative mortality rate was 18.8% which was within the expected range. The 2016 figure was 16.4%.

The risk-adjusted 30-day unplanned readmission rate was not reported. The 2016 figure was 12.9%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 63.0% which was worse than expected. The 2016 figure was 64.9%.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 Bowel Cancer Audit, 68.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2016 figure was 69.8%

The risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The 2016 figure was 2.3%.

The risk-adjusted 2-year post-operative mortality rate was 21.9% which was within the expected range. The 2016 figure was 21.1%.

The risk-adjusted 30-day unplanned readmission rate was 11.3% which was within the expected...
range. The 2016 figure was 11.0%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 44.4% which was within the expected range. The 2016 figure was 44.4%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 2.2% for Abdominal Aortic Aneurysms. This was within the expected range. The 2016 figure was 2.4%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 33 days, which was worse than the audit aspirational standard of 14 days. The 2016 figure was 28 days.

The 30-day risk-adjusted mortality and stroke rate was 2.2%, which was within the expected range. The 2016 figure was 2.7%.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.7% for Abdominal Aortic Aneurysms. This was within the expected range. The 2016 figure was 0.8%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 12 days, which was better than the audit aspirational standard of 14 days. The 2016 figure was also 12 days.

The 30-day risk-adjusted mortality and stroke rate was 3.7%, which was within the expected range. The 2016 figure was 2.9%.

(Source: National Vascular Registry)

National Oesophago-Gastric Cancer National Audit

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the 2017 National Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 13.8%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2016 figure was 9.5%.
The 90-day post-operative mortality rate was 2.7%. This was within the expected range. The 2016 rate was 4.4%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.7%. This was similar to the national aggregate. The 2016 figure was 33.7%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 National Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.0%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation.

The 90-day post-operative mortality rate was 4.0%. This was within the expected range. The 2016 rate was 6.1%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.7%. This was similar to the national aggregate. The 2016 figure was 33.7%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80%
and red ratings indicate performance under 50%.

**Good Hope Hospital**

In the 2016 National Emergency Laparotomy Audit (NELA), Good Hope Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 167 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 108 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 94 cases.

The site achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 65 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 167 cases.

*(Source: National Emergency Laparotomy Audit)*

**Patient Reported Outcome Measures**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2016/17 performance on groin hernias was about the same as the England average for both indicators.

For varicose veins, scores for the Aberdeen Varicose Vein Questionnaire showed a higher proportion of patients that felt they had improved than the England average. However, for the varicose veins EQ VAS the trust had a higher proportion of patients who reported that they felt worse than the England average.

The trust did not submit any data for hip or knee replacements.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was similar to the England average for the EQ VAS indicator but better for the EQ-5D Index.

For varicose veins, performance was better than the England average for both the EQ VAS and EQ-5D Index. Performance was similar for the Aberdeen Varicose Vein Questionnaire.

For hip replacements, performance was worse than the England average for the EQ VAS and similar to the England averages for EQ-5D and Oxford Hip Score.

For knee replacements was about the same as the England average for all three indicators.

*(Source: NHS Digital)*
The performance in the PROMs for hip and knee replacements may have been affected by a low patient participation rate. An external organisation was not employed by the trust to follow up patients and encourage participation, thus increasing participation rates. Good Hope hospital cared for elective and trauma patients on the same ward. This has been shown to affect infection rates and outcomes.

Surgical services participated in the national radical prostatectomy outcomes project. Median post-operative stay was three days as compared to three days nationally for open surgery and was in line with national data for laparoscopic surgery.

Staff completed a study to investigate and improve surgical site infection following abdominal surgery. They completed a before and after study to determine the impact of additional measures to prevent surgical site infections. An evidence-based bundle of care comprising pre-operative, intra-operative, and post-operative measures was implemented. The study identified that SSI remained a major burden to patients after abdominal surgery. Introduction of the bundle significantly improved compliance with appropriate antimicrobial prophylaxis and significantly fewer patients required unplanned readmission; the observed rate of incisional SSI was reduced from 29.3% to 21.7% following implementation of the bundle of care.

(Source; DR193 SSI Bundle Abstract)

The SHMI performance for Birmingham Heartlands hospital, Good Hope hospital and Solihull hospital for the period April 2017 to December 2017 was 92 the expected level is 100. There were 3,281 deaths compared with 3,554 expected. HGS’s HSMR for the period April 2017 to March 2018 was 102 which is within acceptable limits. There were 2,816 deaths compared with 2,755 expected. (PIR)

**Competent staff**

**The service made sure staff were competent for their roles.**

**Managers appraised staff’s work performance.** Managers held supervision meetings with staff to provide support and monitor the effectiveness of the service.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.

All the staff we spoke with told us they had received an appraisal within the last 12 months. They said they had the opportunity to discuss their performance and their training and development needs.

Nurses were supported through the process of revalidation.

The service had effective policies and procedures for recruiting, training and supporting volunteers.

**The learning needs of staff were identified and training was provided to meet these needs.**

Staff were supported to maintain and further develop their professional skills and experience.

Each ward had a range of champions or link nurses who had undertaken additional training in their link role, to enable them to provide advice to other staff on the ward. They also provided practice based training or updates where appropriate.

A surgeon explained how there was ‘great training opportunities’ for medical staff to develop their skills. For example, surgeons encouraged junior doctors to help with certain surgical procedures to develop their skills.
Medical students were actively encouraged to observe surgery with the surgeon explaining each stage of the operation in detail as they went along.

For a particularly complex surgical procedure, consultant surgeons and doctors in training had been sent to Basingstoke hospital for training.

**There were practice development teams to help nurses with developing their skills.** For example, there was one full time practice development team in theatre.

Staff working in operating theatres worked in different theatres which helped to develop and widen their skills and helped with staff retention.

**Specialist nurses provided education for staff.** For example, a clinical nurse specialist (CNS) had developed a training package on the online educational platform for nurses which was available through the colorectal website.

**There was weekly in-service training available for the therapy team members.** For example, this included cough-assist, non-invasive ventilation (NIV) and supporting patients on intensive care for band 5 staff. Training was led; alternate weeks, by the respiratory team and medical staff. This helped to increase and develop the skills of physiotherapists.

**Appraisal rates**

From April 2017 to March 2018, 89.9% of staff within surgery at the trust received an appraisal. This is above the target for sites of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>367</td>
<td>378</td>
<td>97.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>451</td>
<td>481</td>
<td>93.8%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>66</td>
<td>73</td>
<td>90.4%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>37</td>
<td>41</td>
<td>90.2%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>945</td>
<td>1,052</td>
<td>89.8%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>389</td>
<td>454</td>
<td>85.7%</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>10</td>
<td>12</td>
<td>83.3%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>295</td>
<td>358</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

**Good Hope Hospital**

From April 2017 to March 2018, 90.2% of staff within medicine at Good Hope Hospital received an appraisal compared to a target of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>61</td>
<td>63</td>
<td>96.8%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>108</td>
<td>118</td>
<td>91.5%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>29</td>
<td>32</td>
<td>90.6%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>155</td>
<td>177</td>
<td>87.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>4</td>
<td>6</td>
<td>66.7%</td>
</tr>
</tbody>
</table>
Multidisciplinary working

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

All relevant staff, teams and services were involved in assessing, planning and delivering patients’ care and treatment.

Staff worked collaboratively to understand and meet the range and complexity of patients’ needs.

Multidisciplinary team meetings (MDT) were held including all relevant professionals involved in the care and treatment of patients. This helped to ensure that decisions were made based on all medical, social and nursing knowledge and that the most appropriate care and treatment was delivered based on the individual patient and their needs.

Patients’ discharge, transition and referral plans considered patient’s individual needs, circumstances, on-going care arrangements and expected outcomes. Physiotherapists and occupational therapists held weekly meetings to discuss how best to assist patients’ therapy needs including what help they needed for discharge.

A good example of MDT working included a surgical ‘Pelvic Service’ which consisted of surgeons working across two hospital sites to meet the needs of patients undergoing pelvic floor surgery (Good Hope Hospital and Birmingham Heartlands Hospital) as joint partnership working.

Four palliative care nurse specialists worked alongside other professionals to ensure patients’ needs were met. During our inspection, the palliative care nurse specialist was visiting two patients on ward 16.

Seven-day services

Patients received the same care and treatment seven days a week.

Specialist nurses who worked Monday to Friday left plans in place for patients over the weekend.

Four physiotherapists and three physiotherapy assistants worked over the weekends and had a weekend list of patients to be seen, mainly patients with complex needs such as chest conditions. Before physiotherapist could be on call out of hours they had to have competencies in place including ITU, NIV and cough assist competencies.

A patient and their relative said they received the “same treatment at weekends as in the week”.

Consultant surgeons worked over weekends so that each surgical patient had a surgical review every day. Surgeons carried out ward rounds before 12 midday at weekends.

The outreach team and senior sisters triaged jobs for the weekend (surgery at night) and after 12midday at weekends.

Medical staff were also on call and staff had the bleep numbers for calling medical staff. Consultants held meetings on Fridays to handover the handover weekend plan (all were on call).

Health promotion

Staff were consistent and proactive in helping patients live healthier lives. There was a focus on early identification and prevention and on supporting patients to improve their health and wellbeing.
This included advice on how to stop smoking (smoking cessation nurse), drug and alcohol advice (drug and alcohol liaison nurse) and advice from the dietician about special diets.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff understood their roles and responsibilities under the Mental Health Act (MCA) 1983 and the Mental Capacity Act 2005.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed.

**Staff knew how to apply the MCA.** When patients lacked mental capacity to make particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. Nursing and medical staff were able to explain when mental capacity assessments needed to be completed and that decisions were made in the person’s best interests. Staff were able to show us a patient on the ward who had had an MCA recently and the relevant documentation was in place. Staff told us they assessed each patient’s capacity to make a decision about their surgery and consent form 4 which included assessment of capacity and best interest decision was utilised when applicable.

Where a patient’s first language was not English, the service used a translation service so that patients were fully informed. Sometimes staff were available who spoke the same language and could translate directly for the patient.

The trust had a consent policy based on national guidelines and recommended national consent forms were used. The review date for this policy was March 2018. The trust told us policies and procedures were being updated following the acquisition.

We saw that procedures, along with potential risks and benefits were discussed at the outpatient visit and explained again on the day of admission.

**Consent for surgery was gained prior to admission and re-visited on the day of surgery.**

We checked seven consent forms and found they were fully completed and signed by the patient and doctor carrying out the procedure.

We observed, during consultations in the outpatients’ clinic, that details about treatment were fully discussed with patients and the risks and benefits fully explained. Patients were invited to ask questions and did so and told us afterwards they felt fully informed.

**Deprivation of liberty (DoLS) was recognised and only occurred when it was in a patient’s best interests, was a proportionate response to the risk and seriousness of harm to the patient, and there was no less restrictive option that could be used to ensure the patient received the necessary care and treatment.**

We saw where a DoLS was in place for a patient and the staff knew that this would only last for seven days (urgent authorisation) then a standard authorisation would have to be completed by the supervisory body. The supervisory body is the local authority or local health board that is responsible for considering a deprivation of liberty request received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust combines safeguarding level 2, mental capacity and deprivation of liberty (DOLs)
A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>179</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for this module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in surgery at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>88</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this module. The trust had an action plan in place to improve this.

**Is the service caring?**

**Compassionate care**

**Patients were respected and valued as individuals.**

Patients thought that staff really cared and went the extra mile and their care and support exceeded their expectations.

Staff showed direct compassion to patients. For example, staff told us that a patient with a terminal illness informed them of a wedding anniversary. Staff arranged for the patient’s spouse to visit from the nursing home where they resided and they decorated the patient’s room and organised a party celebration on the ward.

Staff not only showed care and compassion to patients but they demonstrated this to each other and this in turn created a caring culture. Relationships between patients, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.

A consultant surgeon referred to “hidden care” where medical and nursing staff worked over and above their job roles to ensure patients received the best possible care and treatment when they
needed it. This was not always seen by the public but happened daily to ensure patients were treated and cared for not only safely and effectively but also and always with care and compassion.

There was a person-centred culture. Staff recognised and respected the totality of patients’ needs. They took patients’ personal, cultural, social and religious needs into account when delivering care.

Patients and visitors were complimentary about the staff and comments included, “He doesn’t want to leave” and “Staff are so kind and helpful”.

**Friends and Family test performance**

Because it related to the same legal entity, University Hospitals Birmingham NHS Foundation Trust, we have used this to form part of our judgement. Data for Heart of England NHS Foundation Trust has only been included post-acquisition.

**Good Hope Hospital**

The Friends and Family Test response rate for medicine at the Good Hope Hospital was 17.5%. A breakdown by ward is below (please note, only wards with at least 100 responses are shown).

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total responses</th>
<th>Response rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Apr-18</td>
</tr>
<tr>
<td>Day cases</td>
<td>1261</td>
<td>15%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 15</td>
<td>126</td>
<td>50%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 16</td>
<td>159</td>
<td>44%</td>
<td>94%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

**Emotional Support**

Staff provided emotional support to patients to minimise their distress. Patients had access to specialist nurses and a multi-faith chaplaincy service.

We saw nursing staff providing care to patients and asking how they were feeling and offering words of comfort when patients were upset. For example, we saw a health care assistant gently placing an arm around a patient and reassuring them as the patient was shouting out and was confused. This helped to calm the patient.

Patients’ emotional and social needs were seen by staff as being as important as their physical needs. We saw the palliative care nurses supported patients and their families with their emotional needs. We also saw the CNS nurses supporting patients with the prospective of major bowel surgery.

Patients were supported to maintain their relationships with those close to them. The trust had an ‘open visiting policy’ where visitors were welcome at any reasonable time. Relatives said they felt involved and included.

**Understanding and involvement of patients and those close to them**
Patients and those close to them were active partners in their care. Staff were fully committed to working in partnership with patients.

Patients’ individual preferences and needs were always reflected in how care was delivered. A patient and their relative said “we have been kept very informed and involved”. Other patients and visitors we spoke with said they had been kept informed.

Staff showed determination and creativity to overcome obstacles to delivering care. For example, a patient had been admitted as requiring abdominal complex surgery and the theatre list was already full for that week. However, this was re-arranged without having to cancel anyone else. This involved staff carrying out two lengthy HIPEC procedures, one on one day and one the next. All the staff teams rallied together to support the patient so that surgery could take place. The patient and their relative said this was ‘marvellous’ and was ‘better than anywhere else’ they had been treated.

Patients were always treated with dignity by all those involved in their care, treatment and support. Consideration of patients’ privacy and dignity was consistently embedded in everything that staff did.

Patients told us they felt really cared for and felt that they mattered. Patients valued their relationships with the staff team and felt that staff often went the extra mile for them.

We observed excellent interactions and involvement of patients. For example, we observed a surgeon providing a patient with information. This was delivered verbally and followed up by the colorectal nurse specialist (CNS) who provided additional information both verbally and through leaflets. The CNS provided the patient with a telephone contact number and was heard to say, “I will go at your own pace”. The CNS told us lots of information was given to patients prior to surgery for example, stoma site and stoma care, as this had been found to speed up patient recovery following surgery.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people. Following the acquisition, the service was moving towards integration of surgical services whilst considering local needs.

The senior leadership team were in the process of reviewing the provision of surgical services across the trust following the acquisition. They were considering the most appropriate configuration in terms of specialty surgical provision that might be concentrated on one site, whilst maintaining local delivery of core surgical services to meet patient need. They were working with the local commissioners and other stakeholders in this process.

The trust was moving towards a provider alliance with a neighbouring trust specialising in orthopaedic surgery, to improve orthopaedic referral to treatment times. They were working with this provider to develop a winter plan for the forthcoming winter period.

Surgical services were provided in an environment which, on the whole, was suitable for their needs. Wards were divided into single sex bays and there were a small number of side rooms that were mainly used for patients with infections. Bathrooms and toilets were designated as single sex, and the service was compliant with Department of Health guidance on single sex accommodation.

**Average length of stay**
University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Good Hope Hospital

From March 2017 to February 2018 the average length of stay for surgical elective patients at Good Hope Hospital was 4.1 days, which was similar to the England average of 3.9 days.

Average lengths of stay for elective specialties:

Average length of stay for elective patients in urology was similar to the England average.

Average lengths of stay for elective patients in trauma and orthopaedics and general surgery were longer than the England averages.

Elective Average Length of Stay - Good Hope Hospital

![Bar chart showing elective average length of stay at Good Hope Hospital compared to England average.]

Note: Top three specialties for specific site based on count of activity.

Over the same period, for surgical non-elective patients, the average length of stay was 6.2 days, which was longer than the England average of 4.9 days.

Average lengths of stay for non-elective specialties:

Average length of stay for non-elective patients in plastic surgery was longer than the England average.

Average lengths of stay for non-elective patients in general surgery and trauma and orthopaedics were similar to the England averages.

Non-Elective Average Length of Stay - Good Hope Hospital
Meeting people’s individual needs

The trust planned and provided services in a way that met the needs of local people.

The needs and choices of different patients were taken into account when delivering and coordinating services, including those with protected characteristics under the Equality Act, patients who may be approaching the end of their lives and patients who were in vulnerable circumstances or who had complex needs.

Therapy staff and nursing staff helped to meet patients’ needs on ‘enhanced recovery’ programme. Enhanced recovery is a modern evidence-based approach that helps people to recover more quickly after having major surgery.

There were systems in place to aid the delivery of care to patients in need of additional support. For example, patients living with dementia had a symbol of forget-me-nots displayed above their beds or on bedroom doors.

A booklet called ‘about me’ was used to capture patient’s individual needs. About me is a useful document recording a person’s needs, likes and dislikes, personal preferences and background. Aimed at helping hospital staff understand more about the person and how best to provide person-centred care during a hospital stay.

Staff told us they were able to provide activities and aids for patients living with dementia. Carers were able to stay with the patient in a side room if requested.

Staff told us that they kept a guide in care plans for patients with communication difficulties. This was so that staff could easily see important information about the patient and how best to provide care and comfort for their individual needs.

Dementia boards on wards contained information for patients, staff and visitors (10 facts that increase dementia).

The trust told us in their information return that it provided comprehensive face to face, telephone interpreting services and written translation services. The services were provided via an external supplier and a small team of in-house interpreting services. The service was provided in all languages including British Sign Language and is available 24 hours a day, 365 days of the year. The in-house interpreting team acted as a hub for all interpreting and written translation booking.
requests and was based at Heartlands hospital. We saw where a patient had received face to face interpretation.

Patients undergoing cytoreductive surgery were seen every day by the physiotherapist team. Cytoreductive surgery is a surgical procedure used to remove tumours from patients with peritoneal mesothelioma.

Therapy staff would review surgical patients who were outliers on other wards.

There was a dedicated peritoneal clinic where medical and nursing staff (including the CNS) spent an hour with new patients.

**Access and flow**

**Patients could not always access the right care at the right time.**

From July 2016 to March 2018, this trust cancelled 2,326 surgeries. Of the 2,326 cancellations, the trust reported that 0% weren’t treated within 28 days. This was consistently lower than the England average.

Over the same two years the percentage of cancelled operations at the trust was consistently higher than the England average.

The senior leadership team told us there had been a concerted effort to improve cancelled operations and referral to treatment times. There were ongoing challenges in trauma and orthopaedics due to bed and theatre capacity and arrangements had been made with the private sector and an NHS hospital to undertake some orthopaedic surgery.

The trust had an overall action plan for cancelled operations and referral to treatment times. Actions included ensuring maximum use of theatre capacity, including scheduling additional lists. There was an action plan in place for each specialty to address referral to treatment times and weekly meetings about them, along with confirm and challenge meetings.

**Patients were usually discharged in a timely way.** Nurse-led patient discharges helped to ensure patients were discharged in a timely manner; patients were given the discharge letter and asked to take to their own GP. If this was not possible the letters would be posted out from the hospital.

Regarding transfer of care, the discharge hub and process to refer patients to them worked effectively.

Wards kept a stock of those medicines that were normally prescribed for patients to take home following surgery and this meant the ward was not reliant on the pharmacy to provide medicines, for most patients. Staff said patients were not normally discharged without the discharge summary being completed and they were able to provide a copy for the patient to take home with them. There was a ‘complex discharge team’ to help staff and social workers plan discharges for patients with complex care needs.

Patients who needed social care in the community could be delayed with discharge. One patient had been waiting for over 100 days at the time of inspection.

**Access to care was managed to take account of patients’ needs, including those with urgent needs.**

The service had an ‘Emergency Theatre Planning Group’ (ETPG). This helped to ensure a safe patient journey, streamlined patient flows, and improved theatre utilisation. There was good communication and team working, and separation of emergency and elective flows.
The document (ETPG) outlined the booking criteria, prioritisation, surgical targets, emergency theatre guidelines and quality control. A copy of this was given to the emergency theatre user group and was discussed twice daily at meetings held at 8:15am and 5pm.

These meetings were attended by consultant surgeons, consultant anaesthetist, and practitioner in charge for theatre three (emergency theatre). The radiographer and floor manager also attended this meeting.

Prioritisation of surgery was carried out based on the clinical needs of patients.

All delays were audited including patients waiting more than 24 hours on the operating list and respective departments were asked to look into ways of improving patient flow.

There was a Surgical Assessment Unit policy in place to help patient flow.

Waiting times to admit, treat and discharge patients were in line with good practice.

The Day Surgery unit was where all surgical patients waited before being transferred to theatre. Patients from ward two and patients admitted as emergencies were transferred from admitting wards.

The bed manager visited the recovery area to allocate beds during the morning. This allowed surgeons to continue operating and not have to wait for post-surgery beds. However, critical care beds were not always available. On occasion the recovery area would keep patients longer if there were no beds in critical care.

When recovery was full this would be escalated to the bed manager. There was a process in place for staff to follow.

Due to the lack of beds in medical wards, many patients were placed in other departments' wards (usually in surgical wards). These patients were called "medical outliers". Most days there were medical outliers on surgical wards and staff felt concerned that they may not be meeting patient's needs as well as if the patient was being nursed on the appropriate ward. On each of the four wards we visited there were medical outliers. This was causing problems with patient flow through the department and slowed down the process of patients receiving reviews from their surgeons or clinicians. Patients' needs were met but not always in a timely way as medical staff had to visit other wards to see their patients.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

From August 2017 to March 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was above the England average, however this decreased to a similar level to the England average from April to July 2018.
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for
admitted pathways within surgery for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>96.8%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>91.0%</td>
<td>60.4%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>90.4%</td>
<td>81.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>83.6%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat</td>
<td>75.0%</td>
<td>62.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>72.7%</td>
<td>68.5%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>60.9%</td>
<td>70.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>57.4%</td>
<td>60.2%</td>
</tr>
</tbody>
</table>

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Five specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>98.2%</td>
<td>80.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>94.4%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.6%</td>
<td>77.4%</td>
</tr>
<tr>
<td>General surgery</td>
<td>75.4%</td>
<td>73.5%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat</td>
<td>74.9%</td>
<td>63.2%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>57.8%</td>
<td>69.6%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>43.4%</td>
<td>61.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has
not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Over the two years, this trust cancelled 3,440 surgeries. Of the 3,440 cancellations, the trust had a lower rate of patients not seen within 28 days than the England average for all quarters apart from July to September 2016 and October to December 2017.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - University Hospitals Birmingham NHS Foundation Trust**

![Graph showing percentage of patients whose operation was cancelled and were not treated within 28 days for University Hospitals Birmingham NHS Foundation Trust and England over 2 years.](image)

**Cancelled Operations as a percentage of elective admissions - University Hospitals Birmingham NHS Foundation Trust**

![Graph showing cancelled operations as a percentage of elective admissions for University Hospitals Birmingham NHS Foundation Trust and England over 2 years.](image)

Over the two years, the percentage of cancelled operations at the trust showed was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Heart of England NHS Foundation Trust**
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From July 2016 to March 2018, this trust cancelled 2,326 surgeries. Of the 2,326 cancellations, the trust reported that 0% weren’t treated within 28 days. This was consistently lower than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Heart of England NHS Foundation Trust**

From July 2016 to March 2018, the percentage of cancelled operations at the trust showed a rate consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

*(Source: NHS England)*

**Learning from complaints and concerns**

**Summary of complaints**
Managers treated concerns and complaints seriously, but did not always investigate them in a timely manner.
Trust level

From April 2017 to March 2018 there were 188 complaints about surgery across the trust as a whole. The trust took an average of 38.8 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Of the ten complaints still open at the time of reporting, all had been open longer than the trust’s target of 30 working days, with the longest being open for 252 working days.

The trust must ensure that complaints are addressed in line with their complaints policy.

Patients and relatives knew how to give feedback about their experiences including how to make a formal complaint if they needed to.

Patients and relatives knew that if they wanted to raise concerns they could do so and would be taken seriously and treated compassionately.

The service used the learning from complaints as an opportunity for improvement and staff could give examples of how they incorporated learning into daily practice.

We saw that following a complaint raised by family members regarding a patient fall an action plan was done which included training among staff and learning about the importance of considering the risks when patients may be experiencing confusion.

We reviewed a complaint and the response that showed appropriate investigation and open information provided including the learning from the feedback. A leaflet providing information for families about delirium was produced and we saw this on the ward.

‘A quick guide to answering a complaint’ was displayed in the staff office on ward 16.

At Good Hope Hospital there were 20 complaints; the main theme was ‘all aspects of clinical treatment’ with 11 complaints (55.0%).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2017 to March 2018 there were 2 compliments within surgery for Good Hope Hospital.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The surgical department had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care.

Leaders at all levels throughout the department demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
The senior leadership and management team for surgical services at Good Hope hospital also managed surgical services at Birmingham Heartlands hospital and Solihull hospital. Most surgical specialties were within division 5; however, theatres, anaesthetics, day case and ambulatory surgery were managed separately within the clinical support services division (Division 1). Each team was led by a divisional director, director of operations, finance manager and head of nursing. The head of nursing was supported by matrons who had responsibility for specific specialties and also covered more than one hospital site.

We spoke with the divisional directors and head of nursing for division 5, and other members of the corporate management team. We found they had a good knowledge of the issues and challenges facing the service and were working together to take forward improvements.

Theatres, anaesthetics and day surgery were managed in different divisions which meant there were separate lines of responsibility and there was not always someone with the overall picture. Although we did not see examples for joint meetings between theatres and wards, there were collaborative relationships between the wards, theatres and day surgery and good team working with no evidence of specific difficulties.

Ward managers and senior sisters told us the matrons were supportive and always available on the telephone although the amount of time the matrons spent on site and in the clinical areas was variable. Band 7 staff told us the matrons usually visited the wards one day a week and other staff commented they saw their matron about twice a month. This limited the matron’s ability to oversee care on their wards on a day to day basis, although the matrons themselves told us they felt they had a good understanding of the day to day issues. One matron covered staffing across the division on a daily basis.

Divisional Band 7 meetings were held which the senior sisters attended and found helpful. The meetings provided the opportunity to discuss practice and share learning across the three hospital sites.

Ward managers, senior ward sisters and the theatre manager were aware of their ward’s/theatre’s performance in relation to the quality metrics measured on a monthly basis, the percentage of staff who had completed mandatory training and their appraisal rates. They showed good leadership skills and staff told us they were supportive, helpful and flexible.

The ward managers, senior sisters and theatre manager held regular team or staff meetings and staff told us they were encouraged to discuss concerns, incidents, complaints and improvements to practice. Staff told us they were informed of changes and the results of audits at the meetings.

**Vision and strategy**

The surgical department had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Staff were aware of the trust’s vision to, “Build healthier lives.”

The main focus going forward following the acquisition was the full integration of surgical services across the trust to create a single division for surgery. Progress was being made specialty by specialty and managers told us vascular, plastics, urology, breast and upper gastro-intestinal surgery were leading on this. Therefore, the strategy was based on further integration of services.

Although many of the policies and processes for the Birmingham Heartlands, Good Hope and Solihull sites were separate from those for the Queen Elizabeth Hospital, work was being undertaken to integrate these.
Staff in all areas of the department knew, understood and supported the vision, values and strategic goals and how their roles helped in achieving them.

The trust’s values were clearly embedded in the way all levels of staff throughout the department delivered care and treatment to patients.

Staff thought, on the whole, there were positive organisational changes following the trust acquisition.

**Culture**

Leaders across the surgical department promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Leaders had an inspiring shared purpose, and strove to deliver and motivate staff to succeed.

There were high levels of satisfaction across all staff.

There was a strong departmental commitment and effective action towards ensuring that there was equality and inclusion across the workforce.

Staff were proud of the department as a place to work and spoke highly of the culture.

Staff felt respected, valued and supported and were encouraged to speak up and raise concerns.

There was a strong collaboration, team-working and support across all functions of the departments and a common focus on improving the quality and sustainability of care and patients’ experiences.

Surgeons explained how there was a ‘joint consultant operating’ culture and how they worked together to support each other.

There was an open culture and staff knew about the Duty of candour (DOC) to be open and honest with patients and their families. We were shown an incident which had fallen under the DOC requirements and the DOC had been followed. There was a good culture of learning and sharing.

**Governance**

Leaders used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

We found examples of discussion at specialty and divisional level to identify improvements to the quality, safety and effectiveness of care.

However, there was little engagement or understanding of governance issues below band 7 level.

Surgical services had an established clinical governance framework at divisional and specialty levels. At divisional level there was a quality and safety committee that met monthly and directorates reported to this committee.

We reviewed the minutes of clinical governance meetings held at specialty level and whilst the agenda was not consistent across the different specialties, there was evidence of a discussion of incidents, risks, audits and ongoing operational challenges to the quality of the services. Each specialty had a nominated audit lead. There was good attendance at most meetings although we noted that in most cases junior doctors and ward sisters were not in attendance. We spoke with senior sisters and they told us they did not attend clinical governance meetings, however, the matrons cascaded information from governance meetings at their divisional band 7 meetings.
Theatres, anaesthetics and day surgery held audit days on a quarterly basis when electives surgery was suspended and a planned programme of presentations and discussions took place in relation to learning from clinical audits and incidents and training was provided.

Divisional band 7 meetings were led by the divisional head nurse and these focused on quality improvement initiatives, learning from others and sharing good practice.

Monitoring of serious incidents, incidents and near misses took place monthly. Incidents were investigated thoroughly; outcomes and learning were shared with staff across the trust and not just for the department who had raised the incident.

Managers could easily identify what the current category of incidents reported were across the trust (for July/August 2018). For example, the top 10 were laboratory investigation incidents (there were none for Good Hope hospital). There was one medicines incident, one tissue viability incident and one blood transfusion incident.

Management of risk, issues and performance

The surgical department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Divisional risk registers identified the key risks within each division.

Minutes of the specialty governance meetings showed that risks for each specialty were identified and reviewed.

Nurse staffing was also identified as a risk on the risk register and actions were being taken to address these through an ongoing recruitment programme and the development of associate practitioners.

Service developments and efficiency changes were developed and assessed with input from clinicians so that their impact on the quality of care was understood.

Risks related to insufficient surgical bed capacity were identified in most specialties and had remained on the risk register for over two years. Improvements for surgery at Good Hope hospital included:

Scheduling theatre lists to reduce dropped sessions in all theatre areas.

The employment of two new colorectal consultants.

NHS locum consultant will be extended for six months to increase outpatient capacity.

Review of clinic booking rules to ensure clinics are maximised to full capacity and restructuring clinic codes.

There will be an introduction of additional Saturday theatre lists and weekend sessions by colorectal surgeons.

There will be a movement of simple laparotomy cholecystectomy operations to Solihull Vanguard Theatre.

These proposals will help to decrease waiting times. Trajectory by the end of 2018 will be 83% against a target of 92%.

Information management

Leaders collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service effectively used the information gained from data collection and audits to challenge and improve practice. We saw evidence of the escalation of issues to the quality and safety committee when required.
Medical records relating to each patient’s current admission in ward areas were paper based and stored in lockable trolleys on the wards and we found that these trolleys were locked in accordance with requirements. Nursing daily records of care such as vital signs observations and food and fluid balance charts were stored at the end of each patient’s bed.

Computers used on the wards to access patient information, such as results of investigations, discharge letters and medicines systems, were always logged out when we observed them unattended, thus protecting patient information.

The information used in reporting, performance management and delivering quality care was usually accurate, valid, reliable, timely and relevant with plans to address any weaknesses. Data or notifications were consistently submitted to external organisations as required. There were robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, information technology (IT) systems were in need of updating and staff said they were not always able to access data they required easily. Staff told us an updated IT system would help ensure that systems were used more effectively to monitor and improve the quality of care.

Engagement

Leaders and staff engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Staff told us they enjoyed working for the trust and that where they worked on the wards and in theatres there was a really good staff team.

Staff felt they were listened to and at meetings when they made suggestions for improvement these were taken seriously.

Staff told us that Monthly staff meetings took place although some staff said these were not always every month and some staff felt this could improve.

All staff at all levels told us they felt engaged.

There was a junior doctors’ forum which was working well where junior doctors could make suggestion for improvements.

Learning, continuous improvement and innovation

Leaders and staff at all levels were committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

There was a fully embedded and systematic approach to improvement.

Improvement was seen as the way to deal with performance and for the surgical department to learn.

Staff were empowered to learn and deliver change throughout the surgical department.

Safe innovation was celebrated.

A prime example of innovation was the HIPEC procedure. This hospital was one of only three in the county who offered this procedure.

A new business case had been put forward to the trust in order to develop the HIPEC surgery. Medical staff told us the trust had been very supportive of the procedure. Surgeons had now performed over 200 of these procedures out of which only one had been postponed.

The majority of patients were elective but we saw a patient who was undergoing the procedure as an urgent case.

There was a strong record of sharing this work locally, nationally and internationally.
University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Maternity services have been provided by University Hospitals Birmingham NHS Foundation Trust from April 2018. Prior to this date they were provided by Heart of England NHS Foundation Trust.

The trust has 145 maternity beds across three sites:

**Good Hope Hospital**
- Delivery suite – 20 beds plus two pool rooms and a high dependency bed
- Snowdrop Suite – bereavement suite with one bed and a sitting room
- Ward 4 – 11 beds, mix of induction and inpatient
- Ward 5 – 22 postnatal beds

**Birmingham Heartlands Hospital**
- Aspen Ward – 19 inpatient beds plus seven transitional care beds
- Delivery suite – 23 beds, including 2 high dependency beds plus six induction beds
- Cedar Ward – 19 postnatal beds
- Maple Ward – 26 postnatal beds
- Willow Ward – 3 birth rooms
- Eden Ward – bereavement suite with two beds and a sitting room

**Solihull Hospital**
- Three birth rooms
- Two postnatal rooms

Queen Elizabeth Hospital does not provide any maternity services.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provides consultant led, midwifery led stand alone and alongside units. In addition, there are teams of specialist and community midwives who care for women during their pregnancy and post-natal period.

The trust has maternity services on three sites therefore there will be some similarities within the three reports.

The trust reported their maternity services are working closely with local specialist trust in the Birmingham & Solihull United Maternity and Newborn Partnership in the BUMP project looking at
access, choice and continuity of care across the organisations.

(Source: Acute PIR – Context acute HGS tab)

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From April 2017 to March 2018 there were 9,348 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Heart of England NHS Foundation Trust – Comparison with other trusts in England

(Source: Hospital Episodes Statistics)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Heart of England NHS Foundation Trust by quarter
(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean women are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Safety and safeguarding processes and practices were developed, implemented and communicated to staff through mandatory training. Staff working within maternity were required to complete the trust training modules annually, which included medicines management, fire safety, infection prevention and control and information governance. Additional training was offered and accessible for all staff, delivered through either an online learning system or face to face.

The trust mandatory training programme was under review with a focus on different methods of delivery. We spoke with two practice development midwives (PDM) who told us of their innovative ways of delivering training to staff face to face by incorporating the learning with the format of well-known gameshows. We observed some of the training being delivered, we saw all staff were enthusiastic both delivering and participating. We were told of obstetric emergency training days, which included sepsis and midwifery training days which included safeguarding, female genital mutilation (FGM), diabetes, governance and antenatal screening.

Some midwives completed the Acute Illness Management (AIMs) course, which covered the identification and escalation of a deteriorating woman.

Some midwives and medical staff were undertaking human factors training. Human factors training encourages staff to think about how people might behave in certain situations, particularly when under stress, and how they can use knowledge to improve safety.

Mandatory training completion rate

Good Hope Hospital

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in maternity at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>122</td>
</tr>
<tr>
<td>Medicines management</td>
<td>121</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>121</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>120</td>
</tr>
<tr>
<td>Information governance</td>
<td>118</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>117</td>
</tr>
<tr>
<td>Waste management</td>
<td>114</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>113</td>
</tr>
<tr>
<td>Fire safety</td>
<td>113</td>
</tr>
</tbody>
</table>
Infection prevention and control

<table>
<thead>
<tr>
<th>Course</th>
<th>April 2017</th>
<th>April 2018</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection prevention and control</td>
<td>111</td>
<td>123</td>
<td>90.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>105</td>
<td>122</td>
<td>86.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>103</td>
<td>123</td>
<td>83.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall training compliance rate of 93.5% for qualified nursing staff. The trust’s 90% completion target was met for 10 of the 12 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in maternity at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017</th>
<th>April 2018</th>
<th>Completion Rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate induction</td>
<td>22</td>
<td>22</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>22</td>
<td>22</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>21</td>
<td>21</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>20</td>
<td>22</td>
<td>90.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>16</td>
<td>23</td>
<td>69.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>15</td>
<td>22</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>15</td>
<td>22</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>15</td>
<td>22</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>14</td>
<td>22</td>
<td>63.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Waste management</td>
<td>14</td>
<td>22</td>
<td>63.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>14</td>
<td>22</td>
<td>63.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>13</td>
<td>21</td>
<td>61.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall training compliance rate of 76.4% for medical staff. The trust’s 90% completion target was met for four of the 12 mandatory training modules for which medical staff were eligible. The resuscitation - clinical module had the lowest completion rate, at 61.9%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff we spoke with on inspection responsible for training provided data on the current compliance with mandatory training as of the end of September 2018. The data was trust wide, and was not available split by site.

The compliance with basic life support, including the use of automated external defibrillators (AED), (487 staff out of a total of 587) was 83% with a further 50 staff booked to attend. The compliance with training for blood collection was 95%.

Compliance with emergency skills training was 100% of consultants, 96% of junior doctors and 94.3% for midwives. The compliance rate for midwives included specialist midwives and managers.
who had direct patient contact and were included in the staffing escalation plans but did not include staff on maternity leave or on long term sickness.

Anaesthetists working within maternity were required to attend emergency skills days bi-annually, providing they attended other emergency study days, for example airway management but staff acknowledged it was difficult to obtain good compliance with this staff group. Training staff had escalated this through the governance process and current compliance was 64%, an increase of the previous year of 55%.

**Safeguarding**

Staff understood how to protect women and babies 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.

The Chief Nurse was lead for safeguarding trust wide. Policies, procedures, protocols and frameworks relating to safeguarding were in line with national guidance and staff told us they were easily accessible.

There was a trust wide, band 8 named midwife for safeguarding, who worked closely with other members of the corporate safeguarding team. The trust had band 7 specialist midwives for women in vulnerable circumstances who had responsibilities for safeguarding within their role. This included specialist midwives for women with perinatal mental health concerns, those who experienced substance misuse or domestic abuse, those who were homeless, refugees or asylum seekers, women who were teenagers or who had experienced female genital mutilation. Specialist midwives supported staff to provide care in partnership with other agencies to ensure women were helped, supported and protected.

All community midwives received clinical supervision in group sessions and as individuals on an ad hoc basis as required.

Staff described their experiences raising incidents of safeguarding concerns when women had disclosed their challenges with substance misuse and accessed support for them and their families.

Mandatory safeguarding training included children’s sexual exploitation (CSE), female genital mutilation (FGM) and modern-day slavery.

Clinical staff working with children, young people and/or their parents received training at level three, in line with national guidance. This training included an awareness of Child Sexual Exploitation (CSE), modern day slavery and female genital mutilation (FGM) and outlined responsibilities for reporting and referring cases identified. The trust had an FGM policy to support staff with this. In 2017 the trust reported two identified cases of FGM to the Health and Social Care Information Centre (HSCIC), in line with the statutory guidance by the Department of Health in 2016 for all organisations. The service implemented the FGM Risk Indicator System (RIS) in May 2018. This system flags children deemed to be at high risk of FGM and includes mandatory referrals.

There were FGM ‘champions’ who provide support and training to staff within maternity and other core services.

The trust had a baby abduction policy and staff told us the service used an electronic tag system for babies, which minimised the risk of abduction. Service leads told us the abduction policy was tested across their sites. Further tests were planned.

**Safeguarding training completion rates**
Good Hope Hospital

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in maternity at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>122</td>
<td>123</td>
<td>99.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall safeguarding training compliance rate of 99.2% for qualified nursing staff. The trust’s 90% completion target was met for the only safeguarding training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in maternity at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>19</td>
<td>22</td>
<td>86.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>6</td>
<td>9</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall safeguarding training compliance rate of 80.6% for medical staff. The trust’s 90% completion target was not met for either of the two safeguarding training modules for which medical staff were eligible.

Staff told us they completed safeguarding levels 1, 2 and 3 depending on their clinical role. Face to face training was provided for levels 2 and 3. Data obtained from staff during the inspection showed 88.1% of staff had completed their required level of safeguarding training up to the end of September 2018. A further 50 staff were booked onto the training for the quarter up to the end of December. The trust was unable to further split the data by site or clinical role.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff kept themselves clean but did not always keep equipment and the premises clean.

Systems were in place to prevent and protect women and babies from the risk of healthcare-associated infections. We spoke with housekeepers and maternity support workers (MSW) who described daily cleaning schedules as MSWs did much of the cleaning when housekeepers were not on shift. We saw the schedules were completed and up to date.
During the inspection we observed most of the clinical environment to be visibly clean. However, we found several labour ward rooms were not cleaned adequately and saw bodily fluids on the beds, floors and surrounding walls despite being deemed fit for use. In the obstetric emergency theatres, we found blood spots on equipment and on the floors, therefore we were not assured the cleaning processes were robust. We escalated these issues to senior staff at the time who dealt with the matter immediately.

We were told there was an ongoing plan to update the theatre environment. The building was dated and we saw paint was flaking from the walls in theatre two. We saw plastic sheet fitted to the walls in theatre one in order to mitigate risks of infection. Theatre two was being updated at the time of our inspection. However, the floor was not suitable for a theatre environment as it was not able to be cleaned properly due to disrepair.

Staff had access to a range of infection prevention and control policies, procedures and guidelines on the trust’s intranet site. We saw staff adhere to policies in relation to hand hygiene and some in relation to infection control. For example, we saw staff did not wear watches or jewellery in line with the ‘bare below the elbow’ rule and demonstrated good hand hygiene in all clinical areas.

Staff had access to and used suitable personal protection clothing such as gloves and aprons to mitigate against infection.

There was a sufficient supply of hand sanitising gels, which were regularly checked. Sinks were available throughout the clinical area with handwashing prompts for staff, women and visitors.

All areas had disposable curtains and we saw the curtains looked visibly clean and had dates written on them to remind staff when they needed to be replaced.

Staff we spoke with knew the pool-cleaning regime.

Cleaning chemicals were stored in locked cupboards so not accessible to members of the public. This was in accordance with the Control of Substances Hazardous to Health standards. Under the Control of Substances Hazardous to Health Regulations 2002, employers need to either prevent or reduce their workers’ exposure to substances that are hazardous to their health.

Midwife and consultant antenatal clinics were held at Good Hope Hospital, however environment in Antenatal clinic was very cramped. We saw an administration office also being used as a clinical area for MSWs to take observations and test urine, separated by a curtain. Staff told us there was a lack of space and there was nowhere else they could use.

Maternity care records included infection prevention information and prompts for women in an attempt to reduce the spread of healthcare acquired infections. We requested data from the trust for all infections and readmissions across all of the maternity service, however the data that we received was limited and did not include puerperal sepsis and other infections. This data was also not included on the obstetric dashboard. Data provided by the trust for the six-month period from April to September 2018 showed one maternal infection with E-Coli (pre 48 hour). Data provided within the report to the Obstetrics Quality and Safety group from July 2018 showed, from April to August 2017, the surgical site infection (SSI) rate for women across the trust averaged 18%. The lowest rate was 12.5% in May and the highest was 22.7% in August. The England average for SSI was 9.6%. We saw this was one of the quality improvement workstreams.

The trust provided details of environmental audits for the maternity unit. For the three months prior to 29 October 2018, we saw the self-audit scores for all the wards at Good Hope Hospital were above 97%, apart from ward 5 which was 92%. The infection prevention and control team had
audited the Delivery Suite in October 2018 and the scores were 94% respectively. However, in view of our findings on inspection, we were not assured the audit process was robust.

Environment and equipment

The service had some adequate premises and equipment and looked after them well.

All ward areas were tidy and clutter free. The delivery suite had two theatres which were used predominantly for emergency procedures as there were no elective caesarean sections lists at Good Hope Hospital, however one elective caesarean section was performed during our inspection due to a lack of neonatal bed availability at Heartlands Hospital.

The maternity unit was housed within a building that was built some decades ago, however the delivery suite met more recent recommendation from the Department of Health, birthing rooms should include en-suite facilities (DH Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities, 2013).

The delivery suite had two birthing pools, which were clean and well-maintained evacuation procedures were in place to remove a woman from the pool in an emergency.

Emergency equipment was easily accessible and checked daily in accordance with the trust’s policy. The adult and neonatal resuscitation equipment including the resuscitaires in all areas were checked daily. Resuscitaires are used as a warming therapy platform with facilities for managing a clinical emergency.

Cardiotocography (CTG) machines were available for women who required continuous electronic fetal heart monitoring. A CTG machine is used to record both the baby’s heart rate and uterine contractions during pregnancy and labour. Its purpose is to monitor the baby’s wellbeing and allow early detection of distress. Staff were also able to directly monitor the baby’s heart rate in labour using a fetal scalp electrode (FSE). This is a device which is attached to the top of the baby’s head and provides a more accurate picture of the baby’s heart rate.

Staff completed temperature checks daily for the fridges in all areas and reported any faults. All electrical equipment we reviewed was appropriately maintained. None of the items were overdue for service and all had a visible safety tested sticker demonstrating when the equipment was next due for service.

Suitable arrangements were in place for the management of clinical specimens and waste disposal. Clinical waste bins were emptied regularly and contaminated sharps were segregated according to their nature.

An intercom and buzzer system was used to gain entry to each of the maternity wards and the delivery suite to identify visitors and staff so women and their babies were protected from avoidable harm. The exits were also controlled in those areas. In addition to this safety measure there was an electronic tagging system to alert when a baby was taken beyond the tagging parameter and doors locked automatically and immediately to minimise the abduction of babies.

Medicines

The service mostly followed best practice when prescribing, giving, recording and storing medicines. The majority of women received the right medication at the right dose at the right time.

Controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation 2001), were stored appropriately in a locked cupboard and the keys held separately from the main keys. We checked the physical stock of the CDs against the stock level recorded in the register and saw
Staff appropriately prescribed, administered and supplied medicines to women and babies in line with relevant legislation, current national guidance and best available evidence.

The hospital used paper prescription and medication administration record charts for women. We looked at five prescription charts. Of the charts we looked at we saw most did not have the woman’s name recorded on every page of the chart and the prescriber’s signature was not always legible. Staff recorded women’s allergies on the prescription chart. The records showed women were getting medicines when they needed them, and any reasons for not giving women their medicines were recorded. These meant women were receiving their medicines as prescribed.

Staff were able to refer to their medicines policy, the up to date British National Formulary (BNF) or ask for pharmacy support if necessary.

Antibiotics were prescribed in line with the local antibiotic formularies.

Most medicines were managed, transported, stored and disposed of safely and securely. We checked drug cupboards and ward trolleys and found them to be locked and secure. Most intravenous fluids were stored in locked rooms in all areas this minimised the risk of them being tampered with. We saw emergency drugs and fluids were stored with other emergency equipment which was not locked away, in line with guidance from the Resuscitation Council UK. However, we also saw not all emergency drugs and fluids were stored in tamper evident containers or wrapping, which is not in line with guidance. We escalated this to senior staff who gave assurance it would be rectified.

Staff told us the trust’s medicines policy included guidance for use of medicines within the operating theatres. The guidance stated some emergency drugs could be pre-drawn by the anaesthetist at the start of the shift, however they should be clearly labelled, dated and signed and to be disposed of if unused at the end of the shift. We saw several emergency drugs had been pre-drawn and were labelled but there was no date or signature on the syringes. This meant staff would not know who had drawn up the medicines or how long it had been there. We highlighted this to theatre staff who removed the pre-drawn medicine.

Medical gas cylinders were stored appropriately. Midwives exemption medicine and patient group directions (PGDs) were clearly marked on prescription charts we checked. PGDs and midwives’ exemptions allow some registered health professionals (such as nurses and midwives) to give specified medicines (such as painkillers) to a predetermined group of patients without them seeing a doctor.

Medical gas cylinders were stored appropriately. Midwives exemption medicine and patient group directions (PGDs) were clearly marked on prescription charts we checked. PGDs and midwives’ exemptions allow some registered health professionals (such as nurses and midwives) to give specified medicines (such as painkillers) to a predetermined group of patients without them seeing a doctor.

Medicines that required refrigeration and freezing were kept at the correct temperature and we saw staff checked and recorded the temperatures each day in all clinical areas. We also saw evidence of room temperatures being monitored. This meant staff were assured ambient room temperatures were not above a suitable range for the medicine within them as high temperatures reduce the shelf life of medicines.

Records

Staff kept detailed records of women’s care and treatment. Records were mostly clear, up-to-date and easily available to all staff providing care.

The trust was moving towards an integrated electronic patient record system which would incorporate antenatal, intrapartum and post-natal care for women. This was part of the strategy for Birmingham & Solihull United Maternity and Newborn Partnership (BUMP) project looking at
access, choice and continuity of care across the organisations. At the time of the inspection staff were using both paper and electronic records and it was planned in time, the system would be fully electronic. Other providers across BUMP would also be using the same system which would allow better sharing of information and continuity of care.

Some confusion was caused by the combined use of written records and computerised notes. We reviewed 10 sets of records Individual records were documented and managed in a way which protected women from avoidable harm.

Main hospital notes included medical details from previous pregnancies or medical conditions. Staff told us notes were readily available for clinics or admissions.

Maternal and baby postnatal records were used in hospital and sent home for the community midwife to deliver care with relevant information to protect them from avoidable harm. A discharge summary was included in the notes and sent to the GP and health visitor prior to discharge from the community midwife.

Inpatient records were stored on wards in secure trollies. We did not observe any time when the trollies were left unlocked when unattended.

Mental health assessments were included in the women’s records with consent. If a woman did not consent to this then staff stored information on the electronic booking record and main hospital notes.

The perinatal mental health team completed detailed antenatal and postnatal care plans for both mothers and babies which had been assessed by them.

We were told spot checks were carried out, however there was no robust auditing of the record keeping system to ensure standards were being maintained. Service leads confirmed there was a plan for all records to be kept electronically by spring 2019 and community midwives would be provided with appropriate equipment to enter data.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman. They kept clear records and asked for support when necessary, however assessments were not always in line with local policies.

Staff carried out full risk assessments of women at their initial booking visit. The booking record was kept electronically and pregnant women were given a copy of their antenatal care to keep with them, including a copy of any ultrasound scan report. These included social, medical and mental health assessment and referral as necessary. Other assessments included tobacco and drug use, family history and previous pregnancies. These assessments were used to classify the woman as ‘low’ or ‘high’ risk. Low risk women continued with midwifery-led care, whilst high risk women were referred to consultant-led care.

Assessments of venous thromboembolism and of immunisation history were also recorded. Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most common in a leg vein, where it is known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE). The service audited compliance with the trust’s VTE screening tool. From our review of the minutes of the Obstetrics and Gynaecology Quality and Safety meeting in October 2018, compliance was 98.42%.

CTG monitoring was used only when it was clinically indicated as per NICE clinical guideline 190, intrapartum care for healthy women and babies (last updated February 2017). We saw evidence midwives followed the hourly buddy approach for CTG interpretation and classification during
labour. The buddy system required a second midwife to review the fetal heart trace and contractions to ensure there had been correct interpretation and management. This was in accordance with national recommendations. Multidisciplinary CTG case reviews were held regularly to facilitate discussion and learning.

The maternity risk assessment booklet completed for each admission included a Modified Early Obstetric Warning Score (MEWS) and action plan. The MEWS was used to assess the health and wellbeing of women who were identified as being at risk. This paper based assessment tool enabled staff to identify and respond to a woman whose health was deteriorating and summon additional medical support if required. The MEWS chart included a prompt to staff to consider sepsis when a woman looked sick or had unexpectedly deteriorated and signposted them to the sepsis screening pathway. The detailed risk assessment booklet included documentation of initial plan. We reviewed 8 clinical records which included MEWS and saw staff were completing them fully and accurately calculating the scores, and were escalating appropriately when the tool indicated a concern about a woman's wellbeing.

Staff used both electronic and paper based methods for recording the handover of a woman’s care. They used the Situation, Background, Assessment and Recommendation (SBAR) forms for handover when women were moved from any of the wards or delivery suite and after a shift change. SBAR is a technique which can be used to facilitate and prompt appropriate communication especially amongst healthcare professionals. SBAR stickers were used in the paper records or recorded in the electronic version. Both staff members were required to sign or acknowledge the handover in both versions.

Midwifery and medical handovers took place twice a day at 7.30am and 7.30pm. The format of the handovers was clear and detailed, identifying the highest risk women, staffing levels and concerns and any issues which affected women on the wards, delivery suite and maternity assessment centre (MAC). Pregnant women requiring advice and care were triaged in the MAC, which formed part of the delivery suite.

Obstetric theatres used a modified version of the World Health Organisation (WHO) ‘Five Steps to Safer Surgery’ safety checklist prior to and during each procedure. This is a process recommended by the National Patient Safety Agency (NPSA) for every patient undergoing a surgical procedure. The process involves several safety checks before, during and after surgery to avoid errors. For each patient's procedure, the checklists in theatre were followed and completed in full. Audit data provided by the trust following the inspection, for the three-month period August to October 2018, showed 99.8% compliance with the WHO checklist within the Delivery Suite emergency theatres at Good Hope Hospital.

We saw swab counts were not documented in the main paper hospital notes when a woman had been to theatre. We checked six sets of records and found one had the section of the notes completed. We escalated this to managers who told us it would always be documented on the electronic records by theatre staff, however they would also expect the paper notes to be completed and agreed to review the process.

We were unable to observe a woman undergoing a caesarean section due to procedures at Good Hope Hospital being of an urgent nature. In the event of an emergency procedure, staff told us sufficient checks would be carried out to proceed without compromising the safety of the woman or baby by delaying the start of the procedure.

There was a dedicated fridge to store blood products located within the obstetric theatre area on the Delivery Suite. There was a blood gas analyser on the delivery suite, in line with national
recommendations. This meant staff could quickly analyse blood products from both women and babies to assist with planning care.

**Midwifery staffing**

The service had enough staff with the right qualifications, skills, training and experience to protect women from avoidable harm and to provide the right care and treatment.

Staffing levels were planned and reviewed to ensure women and babies received care and treatment which protected them from avoidable harm. In 2016, the maternity department used the National BirthRate Plus acuity tool to calculate midwifery staffing levels, in line with guidance from the National Institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a patient). The ratio of midwives was one to 26 women, in line with national guidance.

Staffing levels were displayed on each of the ward areas and delivery suite and during the inspection we saw expected staff levels were mostly in line with actual staffing numbers. There were always two experienced band 7 midwives on every shift, one acted as the delivery suite coordinator who was usually supernumerary and the other provided cover for breaks, support for staff and was the unit bleep holder. Student midwives we spoke with told us they were always supernumerary.

Staff worked a mixture of shifts including earlies, lates, long days and nights and the planned number of qualified staff for Delivery Suite for each shift was nine midwives. At the time of our inspection, we were told there were 18 midwives on maternity leave trust wide, which influenced staffing levels. Staff we spoke with told us the staffing was generally well managed.

**Planned vs actual**

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified midwifery staff in maternity.

The overall fill rate for qualified nursing staff dropped was around 95% for both time periods.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>105.8</td>
<td>109.2</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 2.7% for nursing staff in maternity. This was lower than the trust target of 5% for nursing staff.

The breakdown by site was as follows:

- Good Hope Hospital: 3.4%
Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 12.5% in maternity for qualified nursing and midwifery staff. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:

- Good Hope Hospital: 14.3%

Sickness rates

From April 2017 and March 2018, the trust reported a sickness rate of 5.1% in maternity for qualified nursing and midwifery staff. This is above the trust target of 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:

- Good Hope Hospital: 4.0%

Bank and agency staff usage

From April 2017 to March 2018 the trust reported 28 shifts were filled by agency staff, 5,469 by bank staff and 2,003 shifts were left unfilled across Birmingham Heartlands, Good Hope and Solihull hospitals. A breakdown by site was not provided.

Medical staffing

Access to medical support was available seven days a week. Consultant obstetricians operated a system of consultant ‘hot week’ on a rota, which meant consultants were resident and on call for the delivery suite. Consultant obstetricians were resident on the delivery suite from 8am to 11pm seven days a week. This was in line with the safer childbirth/Royal College of Obstetricians and Gynaecologists (RCOG) recommendations for the minimum number of hours of consultant presence on the labour ward per week. Consultant anaesthetists covered delivery suite from 8.00am to 8.30pm Monday to Friday and from 8.00am to 12.30pm on weekends. Outside of these hours the consultant obstetricians and anaesthetists worked a non-resident on-call system to support the speciality registrars and were available to attend the maternity unit within 30 minutes when requested.

We attended an evening handover which was multi-disciplinary and saw the on-call consultant obstetricians and anaesthetists were present, together with more junior doctors and midwife coordinators.

We attended an evening handover which was multi-disciplinary and saw the on-call consultant obstetricians and anaesthetists were present, together with more junior doctors and midwife coordinators.
An anaesthetist was available immediately always for the maternity unit and was free from other duties.

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in maternity.

The overall fill rate for qualified nursing staff dropped was around 95% for both time periods.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE in month</td>
<td>Fill Rate</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>23.2</td>
<td>95.3%</td>
</tr>
</tbody>
</table>

Good Hope Hospital reported an overfill of two members of medical staff in June 2018.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 2.7% for medical staff in maternity. This was lower than the trust target of 10% for non-nursing staff.

The breakdown by site was as follows:

- Good Hope Hospital: 3.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 and March 2018, the trust reported a turnover rate of 5.9% in maternity for medical staff. The trust only supplied data which pertained to Birmingham Heartlands Hospital.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

Sickness rates

From April 2017 and March 2018, the trust reported a sickness rate of 1.1% in maternity for medical staff. This is below the trust target of 4.0% for Birmingham Heartlands Hospital and Good Hope Hospital.

The breakdown by site was as follows:

- Good Hope Hospital: 1.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From April 2017 to March 2018 the trust reported 251 shifts were filled by locum medical staff, 1,048 by bank medical staff and 89 were left unfilled.

A breakdown by site is below:
<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>117</td>
<td>459</td>
<td>47</td>
<td>576</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

**Staffing skill mix**

In May 2018, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was the same.

**Staffing skill mix for the 99.1 whole time equivalent staff working in maternity at University Hospitals Birmingham NHS Foundation Trust.**

- **Consultant**
  - Trust: 43%
  - England average: 41%
- **Middle career**
  - Trust: 15%
  - England average: 9%
- **Registrar group**
  - Trust: 36%
  - England average: 44%
- **Junior**
  - Trust: 6%
  - England average: 6%

(Source: NHS Digital Workforce Statistics)

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents 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 women honest information and suitable support.

**Never Events**

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

**University Hospitals Birmingham NHS Foundation Trust**

From April to July 2018, the trust reported no incidents classified as a never event for maternity services.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no
more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018, the trust reported no incidents classified as a never event for maternity services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

University Hospitals Birmingham NHS Foundation Trust

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in maternity which met the reporting criteria set by NHS England from April to July 2018.

This occurred at Birmingham Heartlands Hospital in June 2018 and related to a maternity / obstetric incident: baby only (this include foetus, neonate and infant).

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2017 to March 2018.

The breakdown by type of incident reported were:

- Maternity/Obstetric incident: baby only (this include foetus, neonate and infant) with three incidents (75% of total incidents)
- Maternity/Obstetric incident: mother and baby (this include foetus, neonate and infant) with one incident (25% of total incidents)

Site specific information can be found below:

- Birmingham Heartlands Hospital: three incidents
- Good Hope Hospital: one incident

(Source: Strategic Executive Information System (STEIS))

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them where appropriate. Staff reported incidents through the trust’s electronic incident reporting system. Staff working within the governance and risk teams used the electronic system to provide feedback given in response to staff reports, and recorded all the evidence relating to the incident.

Service leads told us they received approximately 250 incident reports per month. At the time of our inspection there were around 30 incidents open and overdue. We were told this was incidents classified as low or no harm and might be due to a review external to the division. No higher risk incidents were overdue. We reviewed minutes of the Obstetrics and Gynaecology Quality and Safety Group meeting from October 2018 and saw the group had sight of the serious incident action log. One action from this meeting was for the clinical service lead to review the serious incident action log to ensure necessary actions were completed and closed.
We reviewed the quality governance report for obstetrics from quarter two (July to September) 2018/19. We saw there were 2312 obstetric incidents reported for the whole service from July 2017 to September 2018. Of these 1735 (75%) were no harm, 537 (23%) were low harm, 35 (1.5%) were moderate harm, four (0.01%) were severe harm and one was catastrophic. The top two sub categories were post-partum haemorrhage for greater than 1000mls and unexpected admission to the Neonatal unit for term babies.

Incidents were being graded according to risk and harm, however we were not assured the grading of some incidents was appropriate. For example, we saw incidents where women had significant bleeding following the birth which is not expected and requires further management and treatment which had been graded as no harm. Other incidents included women who had experienced serious perineal trauma because of childbirth and babies born after 37 weeks gestation who had an unexpected admission to the Neonatal Unit for enhanced care and treatment which was also graded as no harm. We raised this with the trust at the time of our inspection. Service leads explained they considered the grading of all incidents but any incidents where there was no “avoidable” harm were likely to be downgraded to low or no harm. We could not be assured incidents were graded appropriately according to harm.

We saw root cause analysis investigations had taken place in relation to serious incidents. (Root cause analysis is an approach for identifying the underlying causes of why an incident occurred). We reviewed the serious investigation reports for four maternity incidents across the service and saw there had been a full investigation with input from the multi-disciplinary team. Learning from the incident had been recorded along with agreed actions, for example reviewing guidelines or changes to practice and escalating concerns to senior medical staff.

Staff told us of learning from serious incidents, for example one incident had related to a failure to follow up blood results during pregnancy. Staff now used an electronic system to log all blood tests. They also requested lists of all test taken the previous day to ensure none were missed.

Staff understood their responsibilities about the Duty of Candour (DOC) regulation and were aware of the trigger for the application of duty of candour, which was for moderate harm and above. DOC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw DOC had been carried out in our review of four RCAs.

**Safety Thermometer**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, women and visitors. Managers used this to improve the service. Maternity services took part in both the classic and the maternity national safety thermometer scheme. The Classic Safety Thermometer is a measurement tool for improvement focused on the four most commonly occurring harms in healthcare: pressure ulcers, falls, urinary tract infections (in women with a catheter) and blood clots. Data for this was collected on an identified day each month to indicate performance in key safety issues.

The Maternity Safety Thermometer is a national system was designed to support improvements in patient care and experience. The maternity thermometer also records data on one day a month, the proportion of mothers who have experienced harm free care. It records harm associated with maternity, such as perineal trauma, abdominal trauma, postpartum haemorrhage, infection and women’s psychological perception of safety.
We saw safety thermometer data displayed within the unit however it was not prominently displayed.

The service maintained a trust wide maternity quality dashboard. This dashboard included the safety thermometer metrics, apart from women’s psychological perception of safety. These were monitored for the whole month as opposed to one day a month. These metrics were monitored by the clinical governance structure monthly.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness, however not all guidelines had been recently reviewed. Managers checked to make sure staff followed guidance.

Local policies and guidelines were written in line with evidence based standards and guidance from professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG).

At the time of our inspection there were 105 guidelines relating to maternity and 29 of those had passed the date for review. Service leads told us this was an improving picture. The service was working with other providers in the local maternity system, the Birmingham and Solihull United Maternity and New-born Pathway (BUMP) to produce joint guidelines, which we were told made the process slower. The guideline midwife’s post had been vacant from December 2016 until November 2017. The post had been funded for 18 hours per week by BUMP from November 2017, but the trust had not directly funded any hours. During the period there had been no guideline midwife, there had been a lead consultant obstetrician for guidelines, however guidelines were not prioritised and many passed their renewal date. Since the new appointment at least 27 guidelines had been renewed. Service leads told us the expectation was for all guidelines to be in date by January 2019. However, this meant we did not have assurance all guidelines were in line with any new evidence or recommendations and, currently, women might not be getting the most effective care and treatment to ensure they were protected from avoidable harm.

We saw mandatory training incorporated issues which were raised through clinical governance or promoting latest best practice, for example including the use of bladder filling during a post-partum haemorrhage and promotion of aspirin in the antenatal period for women at risk of pre-eclampsia.

Staff told us there was a clinical audit programme and monthly meetings were held to track progress and learning. We reviewed the clinical audit programme provided by the trust following the inspection. Topics for audit included consent and documentation, elective caesarean section, perineal trauma, induction of labour, shoulder dystocia, sepsis, intrapartum fetal monitoring, massive obstetric haemorrhage, small for gestational age babies, reduced fetal movements and antenatal screening. Staff told us monthly meetings were held to track progress and learning.

Antenatal key performance indicators (KPI) monitored performance against nine NICE maternity standards. Performance was monitored for seven of the standards against either acceptable (green) or achievable standards (amber). The trust exceeded the achievable standard in one of the KPIs (ID2 – timely assessment of women with hepatitis B), had acceptable performance in five of the KPIs, but did not meet the standard (red) for one of the KPIs (NP2 – Newborn and Infant physical examination (NIPE) timely assessment of developmental dysplasia of the hip. The trust's performance was 75% against the acceptable level for this standard of 95%.
We reviewed 5 cardiotocograph (CTG) traces. Documentation standards were mostly consistent and in line with the trust’s interim fetal monitoring guideline. Staff carried out hourly ‘fresh eyes’ on the CTG traces. ‘Fresh eyes’ is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications from being missed. The process is recommended by NHS England’s Saving Babies Lives; A care bundle for reducing stillbirth.

The trust had fully implemented the NHS England’s Saving Babies Lives; A care bundle for reducing stillbirth. Elements of the care bundle included reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movements and effective fetal monitoring in labour.

**Nutrition and hydration**

**Staff gave women enough food and drink to meet their needs.**

The delivery suite and wards throughout the unit contained fruit and snacks for women requiring additional food and drink. There were vending machines on the ground floor of the unit and a small café, which was temporarily out of use, however we were told it was well used by women and their visitors.

As part of the acquired Heart of England NHS Foundation Trust, the maternity service had achieved full accreditation in the UNICEF Baby Friendly initiative accreditation programme in July 2013 and was re-accredited in July 2016. The service was due for re-assessment in January 2019.

The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding and raise standards of care for all babies. The UNICEF UK Baby Friendly Accreditation has four levels which starts with a certificate of commitment. Stage one assessment is building a firm foundation, stage two is an educated workforce and stage three is full accreditation. Data obtained during the inspection showed the current breast-feeding initiation rate was 71%, which is about the same as the national average (74%).

Staff monitored the expressed breast milk stored in the milk fridge. During our inspection there was milk in the fridge, which we saw to be labelled adequately and dated. Staff told us it could remain in the fridge for up to 24 hours and then would be disposed of appropriately. The fridge was unlocked; however, it was in a locked room to mitigate any risk of women giving their baby the wrong milk. Staff told us if the baby was in the neonatal unit the milk would be taken there, and if the baby was on the ward the milk would be used within the requisite timeframe. Expressed breast milk can only be stored at room temperature (no more than 25 degrees) for up to six hours.

**Pain relief**

**Staff assessed and monitored women regularly to see if they were in pain. They gave additional pain relief.**

Women’s pain was assessed throughout their pregnancy and admission to hospital, they could access pain relief in a timely manner during labour and post-operatively. Women we spoke to confirmed they were offered pain relief options and given information to make informed decisions. They told us pain relief was offered and administered in a timely manner.

There were two birthing pools on the delivery suite, women could use to ease their pain in labour. Women who were assessed as low risk were able to use the birthing pools for pain relief, although staff told us women who were high risk would have an individual risk assessment and care plan developed with them by medical staff to determine suitability of a birthing pool for pain relief.
Pain relieving gas was piped in all birthing rooms on the delivery suite. Stronger painkiller by injection was available for women who required stronger pain relief.

Epidurals (an injection of anaesthetic into the spinal area) were available for women on the delivery suite 24 hours per day, seven days per week. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance states the average waiting time for women requesting an epidural to receiving one should be within 30 minutes. We were told there was no routine audit of this service.

An assessment of pain was included and scored on the MEWS chart and we saw staff escalated to anaesthetists if they were caring for women and could not control their pain, for example post caesarean section.

**Patient outcomes**

*Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.*

The service maintained a maternity quality dashboard which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008.

The dashboard presented data relating to activity, workforce, antenatal, intrapartum, perinatal, quality indicators and risk. This included data on the number of deliveries, broken down into mode of delivery, trauma at delivery (postpartum haemorrhage; excessive blood loss or perineal trauma 3rd and 4th degree) and neonatal unexpected admission to the neonatal unit. The dashboard captured the number of women who had an induction of labour, and the number of antenatal bookings performed before 10 weeks gestation were also captured. Staff told us an audit for induction of labour had just been completed, although the findings had yet to be analysed. Data was captured relating to the reasons for the induction, the time of admission to the start of the process and the time women waited to have an artificial rupture of membranes if applicable. We reviewed minutes of the Obstetrics and Gynaecology Quality and Safety meeting from October 2018 and saw the maternity dashboard, parameters for outcomes and trends and themes was included in the discussions.

The service submitted data to the National Maternal and Perinatal Audit (NMPA) as part of the acquired Heart of England NHS Foundation Trust and no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement. The audit captures site-specific results for key measures of maternity care. These included instrumental delivery, episiotomy rates (a cut to aid delivery of the baby), induction of labour, early elective caesarean section, babies who were small for gestational age at 40 weeks, low Apgar scores (a guide for staff as to whether the baby needs additional resuscitation at birth) and 3rd and 4th degree tears. Data was submitted for the 11 metrics and indicated the service was performing in line with or better than the expected range for a site of this size apart from episiotomy rates, which 29.3% of all deliveries, which was higher (worse) than the national average of 22.7%. Managers we spoke with were not sighted on the raised episiotomy rates as they had not been discussed at clinical governance or labour ward forum. However, they did not feel episiotomy rates were outside of normal range and told us they had bought specialised scissors to aid technique and staff confidence.

Staff told us the service was part of the first wave of NHS Improvement Maternal and Neonatal Health Safety Collaborative and were using quality improvement methodology. One of the workstreams was around improving compliance with time from decision to surgery for emergency
caesarean section, which should be undertaken in less than 30 minutes. Trust-wide, prior to the workstreams the service achieved 72% compliance, which had improved to over 90% compliance. There was another workstream to improve the number of term babies admitted unexpectedly to the neonatal unit. Staff had worked on producing a care bundle and had changed practice for example the administration of buchal (via the mouth) glucose for babies had improved blood sugars.

**National Neonatal Audit Programme**

**Good Hope Hospital**

In the 2017 National Neonatal Audit Good Hope Hospitals performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

  Of the 46 eligible cases identified for inclusion, 84.6% of mothers were given a complete or incomplete course of antenatal steroids.

  This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

  The hospital did not meet the audit’s recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

  There were no eligible cases identified for inclusion for this measure.

  *(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)*

**Maternity active outlier alerts**

**Standardised Caesarean section rates and modes of delivery**

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>2,898</td>
<td>31.0%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>905</td>
<td>9.7%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>5,543</td>
<td>59.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>9,346</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Source: Hospital Episode Statistics, April 2017 to March 2018*

*Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
\(^1\)Includes elective and emergency caesareans
\(^2\)Includes forceps and ventouse (vacuum) deliveries
\(^3\)Includes breech and normal (non-assisted) deliveries*
**Standardised caesarean section rate (April 2017 to March 2018)**

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesarean s (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>1,357</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.9%</td>
<td>1,541</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.3%</td>
<td>2,898</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. Data includes both University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust.

All elective caesarean sections (CS) from across the service were carried out at the Princess of Wales Maternity Unit at Heartlands Hospital. Very few elective CS were carried out at Good Hope Hospital.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)**

**University Hospitals Birmingham NHS Foundation Trust**

The trust did not take part in the 2017 MBRRACE audit as it as it was prior to the acquisition and they did not provide maternity at that time.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 7.15. This was more than 10% higher than the average for the comparator group of 6.2, placing it in the red band.

(Source: MBRRACE UK)

Approximately 12 months ago, the service recognised women booked for elective caesarean sections were often experiencing delays at Good Hope Hospital because there was no dedicated elective theatre or list. Currently most elective caesarean sections were performed at the Heartlands Hospital, which had improved women’s experience.
Service leads told us the MBRRACE data indicated they were not an outlier in comparison with other maternity services in the local area. The published Public Health Outcomes Framework (August 2017) illustrated the areas where Birmingham performed badly and these included infant mortality and the low birth weight of term babies which was 50% higher than the England average. Service leads told us the still birth rates had improved in 2017 and they were working with other providers in the local maternity system, the Birmingham and Solihull United Maternity and New-born Pathway (BUMP) to further reduce stillbirth, neonatal deaths and extended perinatal mortality rates.

**Competent staff**

The service made sure most staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The service had processes in place to identify training needs and compliance, and address any issues identified.

Multidisciplinary update days were held annually to ensure they had the right skills and knowledge to care for women competently. The courses contained core subjects and some additional subjects according to recent trends and themes or changes.

Practice development midwives (PDM) had undertaken a training needs analysis which was based on the Delivery Suite Strategy to ensure staff were confident and competent to undertake their role. PDMs told us and we observed they had made innovations to the training programme to make the sessions more interactive and engaging for staff, using games and different learning styles and mediums. The training was to be evaluated to assess how effective it was.

We saw the training included sessions covering emergency care for both mothers and babies. Topics covered included major obstetric emergencies including neonatal resuscitation, haemorrhage and maternal collapse, shoulder dystocia (where a baby’s shoulders get stuck during a vaginal delivery), breech birth, cord prolapse, pre-eclampsia (a serious complication of pregnancy), sepsis and fetal wellbeing and CTG interpretation. All staff, including medical staff, were required to pass an assessment for CTG interpretation and we were told there was a procedure in place to support staff who did not reach the 75% pass rate.

There was a dedicated theatre team including operating department practitioner (ODP) and ‘scrub’ nurses who were managed by main theatres. Midwives acted as ‘scrub’ nurses in the obstetric emergency theatres on very rare occasions, when the second theatre was required for an emergency and no other team was available from main theatres. We were told midwives completed training, however we were not assured they were maintaining their competencies as there was no evidence of this being monitored. Given it was a rare occurrence, some midwives told us they did not feel comfortable doing it. We escalated this to managers on site.

The service had received a grant from the Health Education England Training Fund, which had to be spent on external CTG masterclass sessions for all consultant obstetricians and band 7 labour ward co-ordinators, to improve decision making around fetal wellbeing and support for staff caring for women being monitored.

The role of the supervisor of midwives (SoM) was discontinued on 1 April 2017 following changes to legislation. The trust implemented the new A-EQUIP (advocating education and quality improvement) model of midwifery supervision, with professional midwifery advocates (PMAs). All existing SoMs agreed to complete additional training to become midwifery advocates.
The service employed two whole time equivalent (WTE) PMAs to provide support to midwives across the maternity service, one full time at Good Hope Hospital and two part-time staff at Heartlands hospital.

The maternity unit provided some enhanced maternal care in their high dependency room on the delivery suite, some staff had completed additional competencies to care for women and babies at an enhanced level.

The service had processes in place to identify training needs and compliance, and address any issues identified. We reviewed the trust’s Professional Midwifery Service standard operating procedure (SOP) which outlined the structure of the support which would be provided to midwives. The SOP gave clear roles and responsibilities for practice development midwives, professional midwifery advocates and the preceptorship midwife.

Some midwives had completed the acute illness management (AIMs) course which covered the identification and escalation of a deteriorating woman, to care for women in the high dependency beds. The in-house training programme commenced in June 2017 and was included on the service’s TNA. It was planned for all midwives to be trained and recertified on a four-year rolling programme. The training was initially targeted at band 6 and 7 midwives and, data provided by the trust demonstrated 65 midwives (27%) had completed the course. Trainers were senior midwives with either a teaching qualification or had undertaken a “train the trainer” course.

**Appraisal rates**

From April 2017 to March 2018, 86.1% of staff within maternity care at the trust received an appraisal. This is above the trust target of 85% for Birmingham Heartlands, Good Hope and Solihull Hospitals.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>31</td>
<td>31</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>382</td>
<td>439</td>
<td>87.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>60</td>
<td>69</td>
<td>87.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>72</td>
<td>90</td>
<td>80.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>14</td>
<td>21</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

**Good Hope Hospital**

From April 2017 to March 2018, 88.3% of staff within maternity care at Good Hope Hospital received an appraisal. This is above the trust target of 85% for Birmingham Heartlands, Good Hope and Solihull Hospitals.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>100</td>
<td>111</td>
<td>90.1%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>60</td>
<td>69</td>
<td>87.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>3</td>
<td>7</td>
<td>42.9%</td>
</tr>
</tbody>
</table>
Multidisciplinary working

Staff of different kinds worked together as a team to benefit women. Doctors, midwives and other healthcare professionals supported each other to provide good care.

All necessary staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and treatment. For example, neonatal teams worked with obstetricians during the antenatal period to produce care plans for babies. Perinatal mental health teams worked together to provide care for women throughout pregnancy.

Staff in all areas of the maternity service told us they worked closely together to make sure women received person-centred and effective care, this included working with healthcare professionals outside of the trust. We observed good interactions between medical staff and midwives on delivery suite during our inspection and in multidisciplinary handovers. In addition to this staff across both maternity hospitals and neonatal units stayed in regular contact when high risk cases were present or anticipated.

Staff within antenatal and newborn screening and fetal medicine told us of close working relationships with other providers in the local area, to plan care and support women whose babies had been identified as having serious conditions or deformities, which could not be managed solely within the trust. Staff told us there was a high incidence of neural tube defects and anencephaly (a disorder of the brain and head) for babies within the trust. For women who chose to terminate their pregnancies, staff worked closely with bereavement midwives to provide support and care.

A multidisciplinary handover took place twice daily on delivery suite including medical staff, midwives and anaesthetic staff. The handover included discussions regarding women who were throughout the unit. Staff shared relevant information about the women and their babies, including risks and emotional and social needs.

Multidisciplinary teams worked together in a wide selection of antenatal clinics.

The trust had two consultant midwives who were based one at each site and described good multidisciplinary working, particularly in diabetes care.

Seven-day services

Delivery suite had access to middle grade obstetric staff 24 hours a day, with the consultant on call as a minimum standard.

There was 24-hour access to a dedicated obstetric theatre and a theatre team, seven days a week. An anaesthetist was immediately available for emergency work on delivery suite.

Staff told us they had prompt access to diagnostic services such as x-ray, ultrasound, computerised tomography, echocardiography and pathology.

The antenatal clinic was open from 8.30am to 5.00pm five days a week, however the maternity assessment centre offered a seven-day service open 7.30am to 10.00pm. Women could also be seen out of hours where capacity allowed and service leads told us the maternity assessment centre is planned to be open 24 hours a day from April 2019. Scans were provided in both antenatal clinic and the maternity assessment centre.

Community midwives made home visits and held antenatal and postnatal visits seven days a week.

Health promotion
Initial booking risk assessments and ongoing screening monitored and identified abnormalities or risk factors for example raised body mass index, low blood haemoglobin levels and smoking. These were then discussed and care planned with all relevant parties, including women and partners.

Carbon monoxide testing was offered to all women at booking, regardless of their smoking status. Healthy eating and weight management advice was also provided as part of diabetic care for women both before and during pregnancy. Specialist midwives held clinics for diabetic women and provided training for midwives to care for and support women with diabetes. All other women also received support on feeding choices, smoking cessation and healthy eating.

Influenza and whooping cough vaccines were offered to all pregnant women after 20 weeks gestation, by community midwives.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Medical staff informed women about the risks and benefits of obstetric procedures, such as emergency caesarean sections or instrumental deliveries. Written consent was obtained from women prior to surgery. Staff asked for verbal consent from women prior to any procedures or care.

Staff had access to specialist midwives who had particular expertise in dealing with women in vulnerable circumstances. Specialist midwives supported staff to look after women with additional needs. Where possible staff worked with women to plan care to support them to make choices, gain consent and reduce distress during birth.

Post-mortem examinations were offered to families in all cases of stillbirth and neonatal death in order to enhance future pregnancy counselling. Consultants or registrars gained consent from women for all post-mortem examinations.

Mental Capacity Act and Deprivation of Liberty training completion

Good Hope Hospital

The trust did not provide data for completion of mental capacity and DoLS training courses from April 2017 to March 2018 for qualified staff in maternity at Good Hope Hospital.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in maternity at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>6</td>
</tr>
</tbody>
</table>
The trust’s 90% completion target was not met for this training module.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Is the service caring?

Compassionate care

Staff cared for women with compassion. Women and relatives confirmed staff treated them well and with kindness.

We observed staff introducing themselves at shift change and saw them caring for women and babies in a compassionate manner. To gain a better overall understanding of the care provided, we spoke with some women and their relatives who confirmed they were treated well and with kindness and respect.

Women’s concerns were listened to and staff spent time discussing care and options. They took time to interact meaningfully and in a considerate way. Staff discussed the impacts on families from pregnancy through to the postnatal period.

Midwives we spoke with demonstrated good understanding of women’s needs and showed sensitivity towards them and their families.

We saw staff respecting women’s privacy and dignity. Curtains were drawn wherever possible and side rooms were available for privacy.

Friends and family (FFT) data showed an improvement in the number of women who use the service and those who are close to them who responded positively about the way staff treated women. Bereaved families are not included in the FFT. The service devised a bereavement feedback form with input from a national charity, which is sent to families routinely two weeks after their discharge. Data collected by the service for 2017 showed 100% of the feedback included complimentary comments about the service, with 97% of respondents scoring the service eight out of ten or above.

We saw some patient feedback displayed on the wards, however some were out of date. There were lots of thank you cards and photographs displayed on all wards from women who had experienced good care.

Friends and Family test performance

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Friends and family test performance (antenatal), University Hospitals Birmingham NHS Foundation Trust
The trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was suppressed due to low figures in April and May 2018. In June 2018 the trust’s performance was lower than the England average.

Friends and family test performance (birth), University Hospitals Birmingham NHS Foundation Trust

From April to June 2018 the trust's maternity Friends and Family Test (birth) performance (% recommended) was consistently worse than the England average.

Friends and family test performance (postnatal ward), University Hospitals Birmingham NHS Foundation Trust
From April to June 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Friends and family test performance (antenatal), Heart of England NHS Foundation Trust

* Data suppressed due to low number of responses

From July 2017 to March 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was consistently worse than the England average.

Please note – no data is available for November 2017 from NHS England for any trust due to data quality issues.

Friends and family test performance (birth), Heart of England NHS Foundation Trust
From July 2017 to March 2018 the trust's maternity Friends and Family Test (birth) performance (% recommended) was consistently worse than the England average.

*Please note* – no data is available for November 2017 from NHS England for any trust due to data quality issues.

**Friends and family test performance (postnatal ward), Heart of England NHS Foundation Trust**

From July 2017 to March 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

(Source: NHS England Friends and Family Test)

CQC Survey of women's experiences of maternity services 2017
University Hospitals Birmingham NHS Foundation Trust

The trust did not participate in this survey as it was prior to the acquisition and they did not provide maternity at that time.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust performed similar to other trusts for 15 out of 16 questions in the CQC maternity survey 2017 and worse for one question ‘During your labour, were you able to move around and choose the position that made you most comfortable?’

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.71</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.22</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.60</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.21</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.09</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.95</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.48</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.35</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>8.74</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.43</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.58</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.96</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.29</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.73</td>
<td>About the same</td>
</tr>
</tbody>
</table>
Thinking about your stay in hospital, how clean was the hospital room or ward you were in? 3.48 About the same
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? 8.52 About the same

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

Emotional support

Staff provided emotional support to women to minimise their distress.

We observed staff supporting women with feeding and talking through options to encourage them to make their own choice. We witnessed a student midwife offering continued feeding support to one woman who confirmed support was available to her always to help her to maintain consistency in feeding. Staff spoke with great enthusiasm which was visibly evident in their work. Support was appropriate and timely to help women cope emotionally in their care and treatment. Services were available to all women and families throughout the antenatal and postnatal period including bereavement, domestic violence, counselling and perinatal support.

Midwives supported families to collect keepsakes such as photographs and imprints of the baby’s hands and feet after they experienced a loss as part of their bereavement service.

All of the women and families we spoke with were complimentary of the care they received, “I could not fault the care at all, staff are always there when you need anything and nothing is too much trouble.”

Staff told us women’s physical and psychological needs were regularly assessed and addressed whilst in the maternity unit. These assessments included nutrition, hydration, pain, personal hygiene and anxiety. Women we spoke with told us all their needs had been met.

There was a chaplaincy service available across the trust as well as multi faith and support for women and families of no faith. All staff knew how to access the services and spoke highly of the services which were provided. The service maintained a mortuary fridge near to the bereavement suite, which conformed to the guidelines of, and was monitored by the Human Tissue Authority (HTA). This meant women and their families could spend as much time as they wished with their baby without having to face the additional distress of visiting the mortuary. Staff were also able to discharge babies direct from the suite to undertakers or if parents wished to take their babies home for a time. Staff told us it gave great comfort to women, their babies were close by.

Understanding and involvement of women and those close to them

Staff involved women and those close to them in decisions about their care and treatment.

Women told us staff kept them fully informed about their care and treatment and they felt included in the decisions around the care they received. Women were empowered to have a voice so they could have the best possible birthing experience.

Birthing partners were included and involved in the care of their partner and new-born baby and acknowledged when women had different physical or mental health needs. in some circumstances, they could stay and support them, making use of the guest bed which was available on each ward.

Is the service responsive?

Service delivery to meet the needs of local women
The trust provided services in a way which met the needs of local women.

Staff understood and respected the variety of cultural, social, religious and personal needs of the women. There were specialist bereavement midwives who were able to signpost bereaved families to a range of additional support to meet individual needs and beliefs.

Antenatal care was readily and easily accessible to all pregnant women and was sensitive to the needs of individual women and the local community.

Women assessed as low risk from across the trust could choose the stand-alone midwifery led unit (MLU) at Solihull or the alongside MLU at the Princess of Wales Maternity Unit at Heartlands. (Stand-alone means entirely separate to an obstetric unit, whereas alongside means next to or in close proximity to an obstetric unit). Good Hope Hospital did not have a separate MLU.

A large range of consultant clinics were provided to support women’s physical and emotional wellbeing, which included mental health, diabetes and anaesthetic. In addition to those were specialist midwife clinics including vaginal birth after caesarean, teenage pregnancy, substance misuse, homeless and vulnerable women and female genital mutilation. The clinics were held regularly, however the area was so busy they often over ran and women were not seen in turn.

Feedback from women we spoke to confirmed some women and their families were unhappy with the care they received in the antenatal clinics. One woman told us “we weren’t told it would take so long, there’s no organisation or communication, we just have to sit there.”

Parking charges were also a concern for women who had attended for their appointment and waited much longer than anticipated.

Specialist midwives either provided care for women or supported staff to care for women with a number of additional needs. This included; a midwife for homeless women and asylum seekers, immigrant women, midwife for substance and alcohol misuse, maternal mental health midwife, teenage pregnancy midwife, diabetic support midwife and bereavement specialist midwife.

Translation services were used when required through telephone or in person and all staff knew how to access them. Staff communicated well with women and families so they could understand any advice given and had opportunity to discuss options available.

Staff told us communication can be a challenge at times and described alternative ways they can ensure women make informed decisions. They told us many of the staff speak a variety of languages, which is often relied upon and showed us cards were available with common words and phrases in a number of different languages, which were used in day to day conversations about care and treatment.

Menus included meals for specialist diets; menu options included vegetarian, vegan, gluten free and halal and could be requested at short notice. Food choices were varied and offered at different times if required.

Staff we spoke with demonstrated an understanding of the impact their care and treatment had on the overall experience of the women and their families. Midwives specialising in mental health, substance misuse and bereavement were among a variety of additionally skilled staff available to work closely with women and other agencies to ensure they are supported through difficult circumstances and receive continuity of care in the community.

The service lead told us there were plans in place using to charitable funds to redevelop Snowdrop Suite in line with Eden Suite at Heartlands Hospital. This would see the suite become larger, soundproofed and have direct access through a separate entrance as well as the mortuary.
being situated within the suite as it was in a locked room but on the delivery suite. Staff told us it was not ideal but the most appropriate place until the plans are implemented.

Meeting women's individual needs

The service took account of women's individual needs

Maternity hand-held notes showed women’s antenatal, labour, birth and postnatal needs had been assessed, and provided for according to their individual needs. However, the records were only supplied in English and small print, therefore if English was not a first language reading the extensive information would be difficult.

Women had access to their handheld records throughout pregnancy.

Wards displayed posters explaining translator services were available. An interpreting service was available for non-English speaking women and for women who used British sign language. All the staff we spoke with knew how to access this service and had access to cordless phones.

Throughout pregnancy and postnatally, specialist midwives worked closely with mental health and community support teams to make suitable arrangements for women with addition needs. Staff told us they have good support from mental health teams during the day time, however their response throughout the night is very limited and can be difficult to manage if they are required urgently.

High risk specialist clinics saw women with multiple pregnancies. These included care plans specifying the timing of appropriate antenatal care.

All women were assessed at booking for birth place choice. Those women assessed as low risk home births were promoted and facilitated and they had two birthing pools on the delivery suite to offer more choice to women presenting a higher risk.

Bereavement midwives supported and trained staff to provide care for families after a pregnancy loss and could support women from 12 weeks of pregnancy. They supplied clear guidance to staff to ensure all women and families were offered appropriate care and supported to make informed decisions at a difficult time.

Staff provided care on Snowdrop Suite for women and relatives who had suffered a bereavement. A team of specialist bereavement midwives directly supported women and provided support and guidance to staff to enable them to meet family’s needs. Bereavement midwives worked a rota and carried a bleep so they were accessible always to provide advice and support to other staff caring for women. Women could spend time in the Snowdrop Suite for an extended stay. Cold cots were available. The service provided spiritual care and religious support for women and relatives as needed. For example, women could be referred to the chaplaincy service for support 24 hours a day, seven days a week. Multi-faith and no-faith options were also available. Parents were supported with making funeral arrangements where necessary.

Parents were supported with making funeral arrangements where necessary and the bereavement team completed the paperwork, including cremation paperwork and medical examiners involvement. The hospital had a chaplaincy service, which offered support to parents who faced the loss of their baby. Chaplains and pastoral support for all various denominations and faiths or none were available on request. The service was sensitive to women’s cultural and spiritual needs for example they could organise ‘quick release’ discharges or shrouding ceremonies.

Memory boxes, which included photographs and hand and footprints, were made up for parents who suffered a pregnancy loss. The boxes could be stored on the delivery suite until the family was ready to take it home.
Mental health and wellbeing was discussed with all women throughout pregnancy, and staff described an excellent level of support from the mental health midwife. These discussions included difficult and sensitive issues such as domestic violence, sexual abuse, drug use, female genital mutilation and child sexual exploitation.

They acknowledged when women had different physical or mental health needs which required additional support.

Posters throughout the unit offered translation services or information in other formats and languages.

The service did not have a dedicated transitional care ward, however the staff were able to care for those women and babies on the ward. Those who required more specialised neonatal care would be cared for on the neonatal ward.

**Access and flow**

*Women could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with good practice.*

Women mostly had timely access to initial assessment, test results, diagnosis and treatment, in line with National Institute of Health and Care Excellence (NICE) QS22 statement 1. However, we did see women were waiting for long periods of time for appointments in antenatal clinic.

The antenatal and new-born screening for the whole trust was based from a hub at Heartlands Hospital. Staff within the team worked closely with fetal medicines midwives and consultants to see women referred to the team following an anomaly ultrasound scan within three working days.

Women assessed as high-risk women could access appointments at the Good Hope Hospital, Heartlands Hospital or the Women’s centre at Solihull Hospital.

Data provided by the trust showed there had been no closures of the maternity unit to new admissions within the previous 12 months. Staff told us the service managed peaks of activity by diverting women as required between the two obstetric units at Heartlands Hospital and Good Hope Hospital.

**Bed Occupancy**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From April to June 2018 the bed occupancy levels for maternity was 68%, which was higher than the England average of 59%.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From January 2017 to March 2018 the bed occupancy levels for maternity were generally higher than the England average.

The chart below shows the occupancy levels compared to the England average over the period.
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The service monitored complaints, concerns and compliments as part of the divisional clinical governance. We reviewed the Obstetrics and Gynecology Quality and Safety meeting minutes from July 2018 and saw the complaint themes were included in the discussions.

Summary of complaints

From April 2017 to March 2018 there were 11 complaints about maternity services across the trust as a whole. The trust took an average of 25.5 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be resolved within 30 working days.

Of the two complaints still open at the time of reporting both had been open longer than the trust target of 30 working days, the longest being open for 68 working days.

A breakdown by site is below:

- Good Hope Hospital: There were four complaints, the themes were all aspects of clinical treatment with two complaints (50.0%), nursing care with one complaint (25.0%) and communication/information to patients (written and oral) with one complaint (25.0%)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2017 to March 2018 there were seven compliments within maternity.

The breakdown by site is shown in the table below.
<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>3</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Throughout the wards, we saw leaflets and posters explaining how to make a complaint or raise a concern through the Patient Services Department (PSD), formerly Patient Advice and Liaison Service (PALS). The Trust website also gave information on how to make a complaint, however there was no information relating to NHS Complaints Advocacy Services.

Formal complaints were handled confidentially, with a regular update for the complainant. PSD passed complaints to the maternity risk team and managers and these were completed and returned to PSD. Managers discussed the complaints at weekly meetings.

**Is the service well-led?**

**Leadership**

**Staff described most leaders and managers to be visible and supportive.**

University Hospitals of Birmingham NHS Trust provided maternity services as part of the Heartlands, Solihull and Good Hope (HSG) Division 2. Group A of the division included paediatrics, neonates, community school nursing, and health visitors. Group B of the division was gynaecology, obstetrics and community midwifery. Leadership of Division 2 was by the divisional director and, within group B, there were clinical service leads, one specifically for obstetrics. The head of midwifery (HOM) was also the divisional director of operations (DOO) and described her role as more strategic than operational. In addition, there was a divisional general manager and we saw these four key personnel worked closely as a team and communicated well.

The HOM was supported by a deputy HOM and a deputy DOO, a clinical midwifery manager (matron) for the delivery suite and a clinical services site lead (matron).

Most staff we spoke with did not describe the HOM as visible and approachable, however they did tell us the deputy HOM and matrons were more visible and this was in line with the HOM’s strategic role.

**Vision and strategy**

**The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, women, and key groups representing the local community.**

The vision for the maternity service was aligned to ‘Better Births’, the report of the National Maternity Review, published by NHS England in 2016 and the Maternity Transformation Programme. Service leads told us of the work streams currently being undertaken, working with other providers and commissioners for Birmingham and Solihull United Maternity and New-born Pathway (BUMP). This collaboration also included local authorities and voluntary organisations in the local maternity system (LMS). The vision for BUMP is “Every woman will be empowered to access consistent, world-class and holistic care right for them, their baby and their family”.

Some of the aims and workstreams of BUMP include:

- Developing a single point of access for women in the region.
- Increasing the proportion of women choosing to give birth in midwifery led units or home births and supporting women to make informed choices.
- Creating a single maternity electronic patient record (EPR) for all pregnant women.

Improving outcomes for women, their babies and families and the wider population which would also include a decrease in infant mortality.

One part of the joint strategy was to develop a single clinical governance system across the LMS by March 2019, which will include a systematic perinatal mortality review process. We reviewed the monthly highlight report for BUMP, which indicated progress against the project milestones. From the report we saw a joint BUMP approach to clinical governance had been developed and they were in the process of setting up a joint perinatal mortality review and significant clinical incident review group. This had been shared with the board sub-committees responsible for quality and safety within the BUMP providers and were awaiting feedback. They were also working on a joint maternity dashboard and were reviewing indicators and RAG (red, amber, green) ratings.

Staff we spoke with were aware of the BUMP strategy.

**Culture**

Managers across the trust did not always promote a positive culture which supported and valued staff, creating a sense of common purpose based on shared values.

Services on all three sites and the community were run by one maternity management team. They were regarded and reported upon by the trust as one service. Whilst there were common governance and policies, staff reported there still felt a degree of separation in relation to the two main obstetric units. Some senior and specialist staff worked across all sites, however most midwives and doctors worked purely at Good Hope Hospital. Service leads told us new consultants were appointed to trust wide posts, with the expectation they could work at both main sites. Video links were being used more often to encourage attendance at meetings and to avoid travel.

The staff we spoke with told us the needs and experience of the women was the most important element of their work, most staff we spoke with felt supported, respected and valued. Staff told us they were proud of the organisation they worked for.

Staff said they were always encouraged to raise concerns and usually received feedback, however changes were sometimes not implemented in a timely way.

Service leads acknowledged there had been difficulties developing the service as some of the senior medical staff were not as willing to embrace change. We were told Improvements had been made in the culture with planned rotation of band seven midwives to work across both sites. It was hoped this would forge relationships and give a greater understanding of the demands of each area.

**Governance**

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
At the time of our inspection there was 105 guidelines relating to maternity and 29 of those had passed the date for review. Service leads told us this was an improving picture. The service was working with other providers in BUMP to produce joint guidelines, which we were told made the process slower. The guideline’s midwife post had been funded for 18 hours per week by BUMP from November 2017, but the trust had not directly funded any hours. Since the new appointment at least 27 guidelines had been renewed. However, this meant we did not have assurance all guidelines were in line with any new evidence or recommendations and women might be getting the safest and most effective care and treatment.

We saw the service produced a quarterly divisional board quality and safety report and a quality governance report for obstetrics, which we reviewed. The reports summarised data collected from reported incidents, risks, guidelines and audit. We reviewed minutes of the Obstetrics and Gynaecology Quality and Safety group meeting from October 2018 and saw all aspects of governance were scrutinised, including incident reporting and management, infection prevention and control, complaints, friends and family data, clinical document control and the risk register.

A variety of local clinical governance groups fed into the monthly divisional meetings. Labour ward forum meetings were held monthly but were currently held separately for the obstetric units. We were told of plans to merge the meetings in the future. There were monthly cardiotocography (CTG) review, audit and mortality and morbidity meetings where specific incidents were reviewed by staff and senior leads. However, although midwives and labour ward coordinators we spoke with were aware these meetings were held, they told us they did not have time to attend and were not specifically allocated to attend on their rota.

Concerns, themes and trends were escalated to the monthly divisional quality and safety and operations board meeting and upward to the executive board through the corporate clinical monitoring group.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The trust operated a corporate risk register, which incorporated the ongoing risks identified for the maternity service. Risks were entirely recorded and managed using the trust’s electronic incident reporting system. At the time of our inspection the division had recorded five risks for obstetrics and one for community midwifery. Of the total obstetric risks recorded, two were trust wide and included reduced capacity in ultrasound and inadequate provision of training and equipment for the electronic record system. Service leads told us this register was a ‘live’ register as some risks were managed and controlled so were not included on the register. One example of this was staffing, which was a risk, but was managed and controlled through escalation.

The service recorded how long each risk had been on the register, there were three risks which had been on the register since 2016, the oldest was from April 2016. Service leads acknowledged some risks had taken a long time to resolve. For example, the prevailing culture amongst consultants had made it more challenging to resolve the difficulties in antenatal clinic. However, the service had obtained funding for additional equipment for community midwives in order to make access to the electronic record more efficient and would shortly be ordering mobile equipment.

We saw details of the risk register were shared with staff; there were copies of the Divisional Risk Profile in ward areas and communication folders.
At the time of our inspection there was one risk midwife, trust wide. Service leads acknowledge this was not sufficient for the level of work generated across all three sites, and a further risk midwife had been appointed and would be in post by January 2019.

Staff told us all incidents were initially reviewed daily by senior staff. In addition, there was a weekly obstetrics and gynaecology risk meeting (CIRG), attended by the clinical service lead and a senior midwifery lead who reviewed all incidents raised within the service. Potentially serious or high-risk incidents were scoped within 72 hours and reviewed by the divisional director, clinical service lead and head of midwifery, and any immediate actions taken as required. These incidents were discussed at the Clinical Professional Review of Incidents group (CRIP) who would confirm whether it was a serious incident and whether an investigation and root cause analysis was required.

We saw incident themes and trends, together with any actions arising from completed or ongoing investigations were discussed at the divisional quality and safety meetings.

We reviewed the report to the Obstetrics Quality and Safety group from July 2018. This interim report identified nine workstreams which had been introduced to improve the quality and safety of maternity care which included; surgical site infection, learning from excellence, neonatal hypothermia/hypoglycaemia (cold/low blood sugars), category one caesarean section, cervical sweeping in high risk women, induction of labour and fetal monitoring. The report gave details of the aims of the projects, progress to date and the next steps.

An audit trail of all actions taken in relation to any incidents was kept in the electronic incident reporting system, and staff had to complete the “lessons learned” section within the electronic record.

We reviewed minutes of the Obstetrics and Gynaecology Quality and Safety meeting from October 2018. We saw the current risks were listed and there was discussions in the minutes about actions taken and review of the risks.

The service monitored a range of quality and performance measures through ward metrics. Performance was assessed monthly and included medication assessments, infection control, privacy and dignity, post-natal, fluid balance and bladder assessments, pain, communication, assessment of the newborn and equipment checks.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The maternity service collected data around patient activity and outcome. Clear service performance measures were reported through the maternity dashboard, this included red, amber, green ratings to enable staff to identify metrics which were better or worse than expected.

Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible through the trust’s intranet facility. There was sufficient access to computers on the wards. Staff had access to the patient records and diagnostic tests they needed in a timely way.

The trust used a combination of paper and electronic records for women who used the maternity service. Most of the woman’s care was recorded electronically however standardised notes developed by the Perinatal Institute were used for intrapartum care. Service leads told us there was a plan for all records to be kept electronically by Spring 2019. One of the key deliverable outcomes of the Birmingham & Solihull United Maternity and Newborn Partnership (BUMP) was...
for ‘all women would have a single, electronic personalised care plan they have full access to by December 2018’. We reviewed the bi-monthly progress of BUMP and saw they were on track to meet this milestone.

Service leads told us an order to supply additional computer equipment for community midwives had been approved, which would make it easier for them to access women’s records when working away from the hospital.

Arrangements to ensure the confidentiality of identifiable data were generally robust. Across all clinical areas we saw medical records were always secured in a locked trolley or stored in a secure area where staff were working. However, we saw computers were not often left logged on or visible.

The service won the Royal College of Midwives ‘Sands Bereavement Care Award’ in 2017 and one of the specialist midwives also won a ‘Who cares Wins’ award in October 2018, promoted by a national newspaper.

Engagement

The trust engaged well with women, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service engaged with women and the local community through their work with BUMP. Women’s views were fundamental to the overall evaluation of the BUMP workstreams and were being collected in a variety of ways including the use of social media.

The trust reviewed feedback from women as part of the BUMP engagement, who said they didn’t mind being cared for by different midwives during labour, however they preferred to have continuity of care with just one named midwife antenatally and postnatally. They had used this information and implemented this to ensure women were happy with the care they received.

Patient feedback was generally obtained through the NHS Friends and Family test (FFT). In addition, all the wards we visited displayed ‘thank you cards’ from women and members of the public. The wards collected women’s and partners feedback as much as possible. All women were asked to complete a feedback form on departure from the hospital.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Practice development midwives told us and we observed they had made innovations to the training programme to make the sessions more interactive and engaging for staff, using games and different learning styles and mediums. The training was to be evaluated to assess how effective it was.

Staff told us the service was part of the first wave of NHS Improvement Maternal and Neonatal Health Safety Collaborative and were using quality improvement methodology to improve outcomes for women and babies. As part of this process the service used a process across all maternity sites called ‘Learning from Excellence’ (LFE) to encourage staff to nominate their colleagues when they recognise excellent work or practice. This process meant staff received praise from their peers and allowed others to learn and share good practice. At the time of our inspection, staff were completing paper forms, but it was hoped this would soon be electronic. Staff told us 389 LFE nominations had been received since it was introduced as a pilot in April 2017. Each person nominated received a certificate.
Staff in the Maternity Assessment Centre aspired to provide a 'one-stop shop' to improve the service. They were able to perform scans as outpatients, avoiding admissions and enabling women to return daily for checks if required. They planned to increase the number of midwives able to scan to provide better services for women.
Acute services Solihull Hospital

Urgent and emergency care

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations. We included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

We visited Solihull Minor Injury Unit as part of the inspection and this appendix relates to that site.

The inspection took place over two days on the 10 and 11 October 2018. During the inspection we looked at forty-two patient records, spoke with eight patients and thirteen staff. We spoke with departmental leads, a matron, emergency nurse practitioners, health care practitioners, GP’s, a consultant, radiology staff, a pharmacist and reception staff.

At Solihull Hospital there is a primary-care service seven-days a week from 10am to 10pm.

There is also an out of hours GP deputising service (BADGER) that operates from within each hospital site from 6.30pm to 10.30pm Monday to Friday and 10am to 10pm at weekends and Bank Holidays, patients can be transferred to this service following initial assessment if they meet the agreed criteria. A clinical navigator is based in minors and triages all ambulance patients presenting in minors to the correct stream to ensure the patient is seen in the correct stream for their clinical needs.

(Source: Acute PIR – Context acute QEB / Context acute HGC tabs)

Activity and patient throughput

Details of emergency departments and other urgent and emergency care services

- Queen Elizabeth Hospital – Emergency department and clinical decision unit (CDU)
- Birmingham Heartlands Hospital – Emergency department and ambulatory care
- Good Hope Hospital – Emergency department and ambulatory care
- Solihull Hospital – Ambulatory emergency care

(Source: Routine Provider Information Request (RPIR) – Sites tab)

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.
From August 2017 to July 2018 there were 216,385 attendances at the trust’s urgent and emergency care services as indicated in the chart above. Of these 201,607 were type 1 and 14,778 were type 3.

Please note: This includes attendances for April to July 2018 which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.

Total number of urgent and emergency care attendances at University Hospitals Birmingham NHS Foundation Trust compared to all acute trusts in England, August 2017 to July 2018

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 there were 179,805 attendances at the trust’s urgent and emergency care services as indicated in the chart above. Of these 153,728 were type 1 and 26,077 were type 3.

Total number of urgent and emergency care attendances at Heart of England NHS Foundation Trust compared to all acute trusts in England, August 2017 to March 2018
Urgent and emergency care attendances resulting in an admission

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The percentage of A&E attendances at this trust that resulted in an admission increased in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The percentage of A&E attendances at this trust that resulted in an admission remained similar.
between 2017/18 and 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Urgent and emergency care attendances by disposal method, from June 2017 to May 2018

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2017/18 Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>37,001</td>
</tr>
<tr>
<td>Discharged*</td>
<td>62,437</td>
</tr>
<tr>
<td>Referred^</td>
<td>12,627</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,410</td>
</tr>
<tr>
<td>Died in department</td>
<td>192</td>
</tr>
<tr>
<td>Left department#</td>
<td>4,382</td>
</tr>
<tr>
<td>Other</td>
<td>342</td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Urgent and emergency care attendances by disposal method, from June 2017 to May 2018
* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Solihull Hospital

The trust’s 90% completion target was met for nine of the 12 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in urgent and emergency care at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>82</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>82</td>
</tr>
<tr>
<td>Medicines management</td>
<td>82</td>
</tr>
<tr>
<td>Waste management</td>
<td>80</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>80</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>79</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>77</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>74</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>73</td>
</tr>
<tr>
<td>Fire safety</td>
<td>70</td>
</tr>
<tr>
<td>Information governance</td>
<td>70</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>68</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall training compliance rate of 93.5% for qualified nursing staff. The trust’s 90% completion target was met for nine of the 12 mandatory training modules for which qualified nursing staff were eligible.

We asked the trust for updated information on basic and paediatric life support, Leaders told us there were 49 ENP’s that worked across the MIU at Solihull. Of that 39 were in date with basic life support (BLS) training. For the ten that were out of date, three were on long term sick and six
recently expired. All that had expired had been booked onto training as a priority. For paediatric life support (PLS), there were 33 ENP’s that were eligible due to the remaining 16 of the 49 being aligned to either Good Hope Hospital (GHH) or Birmingham Heartlands hospital (BHH). The trust told us that they prioritised staff who were based mainly at Solihull. Of the 33, 24 were trained in PLS (paediatric immediate life support) with dates requested for the remaining 9. The rota was adjusted to ensure that there is always one PLS staff on duty at any one time.

The MIU was primarily staffed by emergency care practitioners. A GP was provided by an external provider and consultants rotated across sites. However, the trust’s 90% completion target was met for 10 of the 12 mandatory training modules for which one medical staff was eligible.

Consultants rotated from other hospital sites, therefore medical staff training rates for Solihull Hospital and Birmingham Heartlands Hospital are included below.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in urgent and emergency care at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>1</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>1</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>1</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>1</td>
</tr>
<tr>
<td>Information governance</td>
<td>1</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>1</td>
</tr>
<tr>
<td>Medicines management</td>
<td>1</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>1</td>
</tr>
<tr>
<td>Fire safety</td>
<td>1</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>1</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>0</td>
</tr>
<tr>
<td>Waste management</td>
<td>0</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall training compliance rate of 83.3% for medical staff. The trust’s 90% completion target was met for 10 of the 12 mandatory training modules for which medical staff were eligible. It is worth noting that there is only one member of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Birmingham Heartlands Hospital

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in urgent and emergency care at Birmingham Heartlands Hospital is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>60</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>56</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>56</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>54</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>54</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>50</td>
</tr>
<tr>
<td>Fire safety</td>
<td>44</td>
</tr>
<tr>
<td>Information governance</td>
<td>40</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>38</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>38</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>30</td>
</tr>
<tr>
<td>Waste management</td>
<td>28</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall training compliance rate of 74.7% for medical staff. The trust’s 90% completion target was met for three of the 12 mandatory training modules for which medical staff were eligible. The waste management module had the lowest completion rate, at 45.9%.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*
A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in urgent and emergency care at Good Hope Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>7</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>7</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>7</td>
</tr>
<tr>
<td>Medicines management</td>
<td>7</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>7</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>6</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>5</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>4</td>
</tr>
<tr>
<td>Fire safety</td>
<td>4</td>
</tr>
<tr>
<td>Information governance</td>
<td>3</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>3</td>
</tr>
<tr>
<td>Waste management</td>
<td>2</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall training compliance rate of 72.9% for medical staff. The trust's 90% completion target was met for four of the 12 mandatory training modules for which medical staff were eligible. The waste management module had the lowest completion rate, at 28.6%.

The trust provided staff with a mixture of classroom and electronic training. Staff had days when they could catch up on all their mandatory training and were happy with the training provided. Staff could access training from home. Alerts were sent to staff three months before their training expired.

Leaders told us that there was a standalone online learning module on sepsis. We asked for figures of staff who had completed this, however the trust was unable to provide this.

There was a sepsis/deteriorating patient pathway in place which included information on the sepsis six bundle and screening pathway; staff were aware of the trusts policy on sepsis.

**Safeguarding**

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

The trust’s 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
Though the trust has reported figures for safeguarding level 1 training, it should be noted that the trust has not designated this as mandatory training.

**Solihull Hospital**

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in urgent and emergency care at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>82</td>
<td>82</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>45</td>
<td>45</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall safeguarding training compliance rate of 100.0% for qualified nursing staff. The trust’s 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible.

**The trust’s 90% completion target was met for 10 of the 12 mandatory training modules for which medical staff were eligible.**

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in urgent and emergency care at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In urgent and emergency care, the hospital had an overall safeguarding training compliance rate of 100.0% for medical staff. The trust’s 90% completion target was met for both safeguarding training modules for which medical staff were eligible.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

**Most staff involved in seeing and discharging patients received level 3 safeguarding children’s training.** We reviewed the training records of band six and seven staff who were able to see and discharge patients and found that all except four were up to date.

**Systems, processes and practices that were essential to keep people safe from abuse had been identified and put in place.** Staff knew how to make a safeguarding referral. Arrangements were in place to safeguard adults and children from abuse that reflected legislation. There were safeguarding adult and safeguarding children policies in place including a
PREVENT policy. PREVENT forms part of the governments counter terrorism strategy and aims to stop people becoming terrorists or supporting terrorism.

**Staff understood their responsibilities and adhered to safeguarding policies and procedures.** Staff showed us safeguarding pages on the trust intranet which had links to other relevant safeguarding documents. Safeguarding was embedded in patient records where there was a safeguarding children section. There was a poster on child sexual exploitation in the waiting area.

**There were processes in place to share safeguarding information and to identify safeguarding concerns if they were missed.** There was no specific child protection information sharing system in place, however staff liaised closely with the trusts safeguarding team and a health visitor checked patient notes three times weekly to ensure safeguarding had not been missed. The health visitor had links with local schools and GP’s. If it was found a safeguarding referral had been missed an incident would be raised on the trusts incident reporting system and staff would be expected to do a period of reflection and a statement. Leaders told us that the safeguarding team at the trust had access to the national database around vulnerable children, this helped if children had moved areas and were not known.

**Staff were knowledgeable around safeguarding and records we viewed reflected this.** Staff gave us examples of when they had made a safeguarding referral. We reviewed forty-two sets of patient records and had no concerns about how staff dealt with safeguarding concerns. The trusts safeguarding team did drop in sessions so that staff could raise any queries.

**Staff could obtain safeguarding advice from various sources if they had a safeguarding concern.** A safeguarding lead was based at Birmingham Heartlands Hospital for staff needing advice. If an adult or child had ongoing safeguarding needs they would be transferred to the acute medical unit (AMU) or transferred to Birmingham Heartlands Hospital who would look at ongoing protection. Staff could speak to the senior staff on the paediatric team based at the Birmingham Heartlands Hospital 24 hours a day if needed. There were systems in place to alert staff if there was a previous or ongoing safeguarding concern.

**The trust recognised Female Genital Mutilation (FGM) and had set up a service to provide support and advice.** Female Genital Mutilation (FGM) was covered within safeguarding training modules. In 2002 the trust set up a well women’s service giving access to a specialist midwife by pregnant and non-pregnant women to give support and health advice to those that have undergone FGM and to decide whether their unborn baby or any other existing female children was at risk of undergoing FGM.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the risk of infection.**

A team of domestic staff were responsible for maintaining standards of cleanliness and hygiene; a cleaning schedule was followed which included emptying bins, cleaning toilets and waiting areas. All areas were visibly clean and tidy. Domestic staff used 'I am clean' stickers to show equipment had been cleaned. Staff kept a daily check list behind the nurse’s station to show other areas had been cleaned such as children’s toys.

Hand hygiene compliance was checked and the most recent results displayed on the unit. We saw that seven hand hygiene observations had been completed on the 8 October 2018 when the department had achieved 100% compliance. The department had achieved 100% hand hygiene compliance rates in May, June and August 2018.
The unit had an infection control link nurse who completed any audits including a commode audit. There was a section in the patients records where staff could record if there were any infection risks such as influenza, diarrhoea and vomiting.

The infection control lead completed an infection control audit tool. The most recent was completed in June 2018 when the unit achieved a compliance rate of 81%. This fell slightly short of the target compliance rate of 85%. As a result, an infection control action plan had been developed. Actions included ensuring trolleys were cleaned weekly, items were cleaned daily and that all blood pressure machines were cleaned after use. The action plan was rated with some areas still rated as red including a badly damaged cupboard and door posts.

Staff were observed to be bare below the elbows, wore personal protective equipment as necessary and washed and gelled their hands between patient contact. We noted staff cleaned down trolleys after patients use. The department had enough hand gel dispensers.

**Environment and equipment**

Children had their own waiting area separate from the main waiting room, however adults waited for x-rays in a separate seating area on the other side of the room. There was a small separate play area separate to adults for children that was filled with toys. However, this was aimed at younger children.

There were arrangements in place for managing waste including the storage, labelling and handling of waste.

There was a waste management policy and a control of substances hazardous to health policy available on the intranet. Sharps bins were in place were not over filled and were collected regularly by an external company. Sharps bins did not have a date on them to show when they were last emptied.

Resuscitation equipment was available and fit for purpose. The minor injuries unit (MIU) had two resuscitation trolleys, one in the paediatric resuscitation and sick adult area and one in an assessment cubicle.

We found gaps in recording on resuscitation trolley checklists and resuscitation trolleys were not tamperproof. However, all items in trolleys were in sealed bags. Staff completed resuscitation trolley checklists daily to indicate equipment had been checked, however there were five gaps in recording on both trolleys throughout September 2018. The children’s resuscitation trolley had specialist resuscitation equipment for babies and equipment such as blood pressure cuffs of varying sizes. Resuscitation trolleys had sealed bags inside, were adequately stocked but were not tamperproof.

Electrical equipment was tested for safety. We looked at eight items of electrical equipment and saw there were stickers in place to show when they were next due to be tested; we found all were in date.

There were several bays with trolleys where emergency care practitioners could assess patients in addition to a theatre area for minor procedures. The minor injuries unit was next to the acute medical unit (AMU) and the x-ray department meaning patients had both services close by. There was a relative’s room that was shared with AMU.

**Assessing and responding to patient risk**

Emergency Department Survey 2016

University Hospitals Birmingham NHS Foundation Trust
We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust scored worse than other trusts for one of the five Emergency Department Survey questions relevant to safety and about the same as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.2</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

The trust scored about the same as other trusts in four out of five questions relating to safety.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust scored about the same as other trusts for all the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
Median time from arrival to initial assessment (emergency ambulance cases only)

Solihull hospital is a minor injury unit so does not receive emergency ambulances. We asked the trust to provide us with all audits and action plans around the Minor Injury Unit. We did not receive any information from the trust in relation to time of arrival to initial assessment specifically about MIU.

Ambulance: Number of journeys with turnaround times over 30 minutes – Solihull Hospital

The unit was a minor injury unit so patients were not brought in by ambulance.

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

The unit was a minor injury unit so patients were not brought in by ambulance. However, unwell patients requiring transfer to another hospital would need an ambulance transfer.

Systems were in place to ensure known risks were flagged up to reception staff. Patients arriving at the unit checked in to the front desk and reception staff completed electronic patient registration forms. Patients were asked about their symptoms by reception staff who would direct patients to the appropriate place. There was an electronic flagging system so that any risks or important information would be highlighted. Reception staff told us when they started in role they were given training and advice including what questions to ask patients. Reception staff were aware of the contact details to the resuscitation team should a patient become unwell.

At the time of the inspection staff were not completing initial assessments of patients to detect those at risk of deterioration or potentially serious conditions. There was no clear process in place to determine the priority of patient’s treatments based on the severity of the condition. Leaders told us that they followed guidance from the Royal College of Emergency Medicine (RCEM). The RCEM guidance around unscheduled care facilities states that all patients should be assessed in a timely manner and if there are delays, then some form of initial assessment will be required to detect those at risk of deterioration or potentially serious conditions. We reviewed 30 patient records to see how long patients had waited without an initial assessment. We found that most patients (17) waited over 15 minutes with two waiting under 15 minutes. Four out of 30 patients waited over an hour to be seen by a clinician, including a paediatric patient with a head injury. We were unable to assess the length of time seven of the 30 patients had waited due to times not being recorded. We were concerned that patients who had walked into the unit and had not been assessed in a timely way could deteriorate without being recognised. We raised our concerns with leaders at the trust and were told that there were processes in place, however, this had not been happening. The trust assured us patients would now be having an initial assessment within 15 minutes and that weekly spot checks and metrics would be completed and fed into assurance reporting. We returned to the unit unannounced a week later and reviewed 20 sets of records. We found that all patients had received an initial assessment that included a full set of clinical observations within 15 minutes of arrival; therefore, we were assured that the trust had acted on our concerns and implemented a process to keep people safe. Pain scores were not recorded in thirteen of the nineteen records of paediatric patients.
Some areas of the waiting rooms were not visible to reception staff. This meant reception staff did not always see what was happening in the waiting area. During our inspection a patient needed an urgent assessment as they had become unwell in the waiting area. The patient had been taken out of the waiting area by staff on a stretcher. We asked reception staff what had happened; however, they were unaware as the patients’ family had gone to the nurse’s station around the corner to ask for help and assistance.

There were pathways and protocols in place for patients who needed additional care and support. A well-stocked resuscitation bay was available for emergencies. The minor injury unit (MIU) had protocols in place for patients including sick children in medical emergencies. For example, we saw a pathway was in place if a sick child attended the department and needed transferring to Birmingham Heartlands Hospital where the paediatric team were based. There was a ‘Solihull MIU to Birmingham Heartlands Hospital Paediatric transfer’ risk assessment and transfer form which covered airway, breathing, circulation, disability and exposure or potential exposure problems, if there were problems identified in any of these areas the child would be transferred as an emergency to Birmingham Heartlands Hospital. Children would also be transferred as an emergency if they had a Paediatric Early Warning Score (PEWS) of five or more, there were safeguarding concerns, mental health concerns or if the clinician/and or nurse had concerns.

There was a well-stocked resuscitation bay with guidelines and protocols in a room shared with AMU. Other pathways were in place such as a chest pain pathway and pathways for gastrointestinal bleeding, back pain, difficulty breathing, head injuries and sepsis. Details of all pathways were kept in folders at the nurses’ station and in the clinical managers office. The AMU was next door if a patient needed a referral. At night medical staff on the medical assessment unit (MAU) checked electrocardiography (ECG) results.

There were clear sepsis protocols in place and staff could explain what they would do if sepsis was suspected. Deteriorating patient adult pathways and the paediatric sepsis six form incorporated Paediatric Early Warning Score (PEWS) and Modified Early Warning Scores (MEWS) and when escalation was needed to a senior doctor. We observed staff taking relevant patient observations during consultations.

Leaders told us that there were still some road signs that could lead patients to believe that the hospital had an emergency department. The trust continued to liaise with the local council in relation to this.

The unit did their best to make the public aware of what injuries could be treated at Solihull Hospital MIU and when patients would need to go to the emergency department. The department had notices in waiting areas to inform patients Solihull Hospital did not have an emergency department but was a minor injuries unit. The notice clearly informed the public that emergency department services for sick children were based at Birmingham Heartlands Hospital and that any sick child would need to be transferred which could delay treatment. Examples were provided of what injuries could be treated at Solihull Hospital and when the patient would need to go to the Heartlands Hospital such as if they had breathing problems, a high temperature, drowsiness or broken bones with deformity.
Nurse staffing

The trust had less whole time equivalent qualified nursing staff than it planned from March 2018 to June 2018. Recruitment was ongoing and remained a challenge. Bank and agency staff were used to fill staffing gaps.

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in urgent and emergency care.

The overall fill rate for qualified nursing staff dropped from 87.9% in March 2018 to 77.3% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>275.5</td>
<td>285.6</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>129.5</td>
<td>161.7</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>59.8</td>
<td>76.5</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>34.0</td>
<td>43.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

There was a rolling advert in place for nursing staff.

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 19.6% for nursing staff in urgent and emergency care. This was higher than the trust target of 5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 10.2%
- Birmingham Heartlands Hospital: 21.7%
- Good Hope Hospital: 21.5%
- Solihull Hospital: 21.6%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

Turnover rates for nurse staffing were 11% this was higher than the trust target of 8%.

From April 2017 to March 2018, the trust reported a turnover rate of 10.1% for qualified nursing staff in urgent and emergency care. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors turnover for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:
Queen Elizabeth Hospital: 1.8%
Birmingham Heartleys Hospital: 14.1%
Good Hope Hospital: 24.6%
Solihull Hospital: 11.3%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

The trust were offering staff incentives to reduce staff turnover rates. These included setting up job plans that offered additional areas of responsibility such as rota writing; providing the opportunity to be involved with audits, ensuring planned development programmes for individual staff and recognising outstanding practice.

Sickness rates

Sickness rates for nurse staffing were 6% this was higher than the trust target of 4%.

From April 2017 to March 2018, the trust reported a sickness rate of 4.6% for qualified nursing staff in urgent and emergency care. This is above the trust targets of 3.6% for Queen Elizabeth Hospital, and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 4.2%
- Birmingham Heartlands Hospital: 4.2%
- Good Hope: 4.6%
- Solihull Hospital: 5.7%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Leaders told us that they were completing formal and informal reviews relating to sickness and that weekly wellbeing checks took place by telephone to support face to face meetings. Additionally, staff were offered gradual and sometimes extended return to work plans.

Bank and agency staff usage

From April 2017 to March 2018 the trust reported 3,075 shifts were filled by agency staff, 16,830 by bank staff and 11,578 shifts were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>851</td>
<td>12,033</td>
<td>7,850</td>
</tr>
<tr>
<td>Other sites</td>
<td>2,224</td>
<td>4,797</td>
<td>3,728</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

From April 2017 to March 2018 the trust reported that for qualified and unqualified nursing staff 8.2% of actual hours were filled by agency staff and 20.2% by bank staff across Birmingham Heartlands, Good Hope and Solihull hospitals. The number of unfilled hours, a breakdown by site and staffing type was not provided.

(Source: Nursing bank agency - HGS PIR Return)
Solihull MIU had nursing and health care assistant vacancies. Due to difficulties around recruitment the department were taking a ‘grow your own’ approach and training current band five staff to be emergency care practitioners. We saw that a health care practitioner had the opportunity to do their associate nursing course.

**Staffing rotas took into consideration skill mix and were completed eight weeks in advance with staff being rotated across hospital sites.** The unit was staffed in accordance with unscheduled care facilities guidance by the Royal College of Emergency Medicine (2009) which states a minimum staffing provision of two health practitioners a shift, one of whom must be a qualified health practitioner. There was one children’s nurse who was also an emergency nurse practitioner (ENP) who did both short and long days and night shifts and who had been trained to see adults with minor injuries. Leaders told us that staff rotated across hospital sites, this ensured the unit had the correct skill mix including a band seven emergency nurse practitioner being on each shift. When the children’s nurse was on annual leave the staff could contact the paediatric team at the Heartlands Hospital for advice. Band five staff were not able to see and discharge patients, this needed to be a ENP of band six or above. The majority of ENP were a band seven. The clinical lead was responsible for planning and reviewing rotas to ensure an appropriate skill mix.

The area where patients were assessed was close to the nurses’ station. This meant patients waiting to be assessed were visible when handover took place.

**Medical staffing**

**There were arrangements in place for 24-hour medical cover with medical staff from the acute medical unit being available through the night if required. Locum and bank staff were used to cover vacant shifts.**

There was a GP on the unit from 8am to 10pm each day, consultant cover was from 10am to 2pm when there was a review clinic. ENP’s could get advice from medical staff on the acute medical unit outside of these hours. As the unit was only for minor injuries unwell patient’s (children and adults) were transferred to the Birmingham Heartlands Hospital. There were four consultants with sub-specialist training in paediatric emergency medicine based at Birmingham Heartlands Hospital. The MIU saw 8911 children between October 2017 and September 2018. Consultants looking after children were trained in paediatric life support with a 95% compliance rate within consultant body.

**Bank and locum staff usage**

**Birmingham Heartlands, Good Hope and Solihull Hospitals**

The minor injury unit at Solihull Hospital used bank and medical staff to ensure shifts were filled.

From April 2017 to March 2018 the trust reported that 6,179 shifts were filled by locum medical staff, 4,194 by bank medical staff and that 861 were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Locum</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>1,137</td>
<td>1,564</td>
<td>99</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>2,632</td>
<td>1,135</td>
<td>432</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>2,222</td>
<td>1,384</td>
<td>328</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>188</td>
<td>111</td>
<td>2</td>
</tr>
</tbody>
</table>
Staffing skill mix

In May 2018, the proportion of consultant staff and junior (foundation year 1-2) staff reported to be working at the trust was similar to the England average.

Staffing skill mix for the 102-whole time equivalent staff working in urgent and emergency care at University Hospitals Birmingham NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>24%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, legible and easily available to all staff providing care. We reviewed 42 sets of patient records, these were found to have relevant information such as patient history, previous attendances, electrocardiograms, medications, allergies and were legible. Some records were paper and others were electronic. For example, test results were electronic.

However, there were gaps in recording in some patient records and paper records were not kept securely. Gaps in records included; the time a clinician saw the patients, General Medical Council (GMC) numbers, pain scores and Nursing and Midwifery Council (NMC) numbers. Staff kept paper records on a tray on the desk at the nurse’s station. However, staff were not always at the nurse’s station, this meant records could be accessed by an unauthorised person.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Audits identified areas for improvement and these were acted upon.

Arrangements for managing medicines kept people safe. There was a locked cabinet on the minor injuries unit for storage of controlled drugs with an alarm that triggered when opened. The cabinet contained checking records which two nurses signed at all times.
The only fridge was in the paediatric resuscitation area as the usual fridge was broken, the fridge was small and cluttered; leaders told us a new fridge had been ordered. We reviewed the recording of the fridge temperatures and found that there were some gaps in recording and that the fridge had been out of the correct temperature range for several days, however this had been identified by staff. Whilst we were reviewing fridge temperatures the pharmacist who had been completing regular checks of the fridge and explained there had been an issue with the fridge thermometer but that a new one had now been supplied and calibrated and this had solved the problem.

Medications were in date and there were folders with drug dosages and calculators for children in addition to emergency medications guidance in the case of anaphylaxis and seizures. There were also weight calculations for an infant child on display, a folder that had information on premedication for neonatal intubation, drug dosages in new born babies. There was a hard copy of British National Formulary (BNF) guidance for children.

Staff recorded prescribed medications within patients records and we saw there was a clear record of any allergies. Many emergency care practitioners were nurse prescribers. A small amount of medication was kept on the ward outside of pharmacy hours to dispense if needed such as simple pain medication and antibiotics; staff were clear not to prescribe medication which was outside of their remit. Prescription pads were kept securely.

Documentation for the paediatric sepsis 6 had children’s ages and recommended treatment around choice of antibiotics and dosage. There were microbiology protocols in place for the administration of antibiotics which were being adhered to by staff. There were policies in place around medicines management and intranet pages with links to medicines management information and the BNF. There was an action to take poster on display for the storage of medications in a heatwave.

The pharmacist completed medication audits. The most recent audit dated May 2018 consisted of twenty-five checks with three areas found to be non-compliant. These included errors being bracketed in a single line and the balance of the controlled drug being transferred to the next page. There were notices on the controlled drugs cabinet to alert staff they had failed the audit and to remind staff of areas needed to improve.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. However, we were not assured lessons learned from incidents were shared amongst staff appropriately.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS
Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust reported no incidents classified as a never event for urgent and emergency care occurring from August 2017 to July 2018.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust reported one incident classified as a never event for urgent and emergency care occurring from August 2017 to March 2018. This related to a misplaced naso- or oro-gastric tubes and occurred in November 2017 at Birmingham Heartlands Hospital.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 18 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England occurring between August 2017 and July 2018.

The breakdown by type of incident reported were:

- Diagnostic incident including delay (including failure to act on test results) with six (33.3% of total incidents)
- Treatment delay with five (27.8% of total incidents)
- Slips/trips/falls with five (27.8% of total incidents)
- Surgical/invasive procedure incident with one (5.6% of total incidents)
- Sub-optimal care of the deteriorating patient with one (5.6% of total incidents)
Site specific information can be found below:
- Queen Elizabeth Hospital (August 2017 to July 2018): 12 incidents
- Birmingham Heartlands Hospital (April to July 2018): three incidents
- Good Hope Hospital (April to July 2018): three incidents

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England occurring between August 2017 and March 2018.

The breakdown by type of incident reported were:
- Diagnostic incident including delay (including failure to act on test results) with three (37.5% of total incidents)
- Sub-optimal care of the deteriorating patient with three (37.5% of total incidents)
- Slips/trips/falls with two (25.0% of total incidents)

Site specific information can be found below:
- Birmingham Heartlands Hospital (August 2017 to March 2018): four incidents
- Good Hope Hospital (August 2017 to March 2018): four incidents

(Source: NHS Improvement - STEIS)

Staff understood their responsibilities to raise concerns, to record safety incidents and to report them. Staff of all levels knew how to report an incident on the electronic system and told us they received feedback when they did. Staff could give examples of incidents they had reported.

**Learning from incidents was not a standard agenda item in the emergency care practitioner meetings.**

We reviewed three sets of minutes from emergency care practitioners’ meetings dated between December 2017 and September 2018 and found that learning from incidents was not discussed. However, incidents were discussed at divisional quality and safety meetings.
Staff were aware of the importance of being open, honest and transparent. There were no recent incidents that required duty of candour. Staff were aware of the basic principles of duty of candour such as being open, honest and transparent. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Leaders could give a good explanation of when it would apply. They told us that they had not had any recent incidents that had needed duty of candour to be followed.

The department was a minor injury unit so they did not take part in mortality and morbidity reviews. There was an incident reporting and management policy that described the trust approach to incident recognition, reporting and management and included the different categories of severity such as low harm, moderate harm, severe harm, catastrophic. A being open policy was in place.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care as all incidents were reported under the core service ‘Other’.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from August 2017 to August 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Major incident awareness and training

Processes were in place to deal with major incidents. Staff had access to information on what to do in an emergency.

There were arrangements in place to deal with major incidents. The unit was the receiving unit in the event of a major incident in the area. There was a disaster room that contained equipment
such as radios, a major incident trolley and high visibility jackets. There was an incident response plans folder on the desk at the nurse’s station and staff knew where to find it. There was CCTV monitoring in place and emergency buttons that staff could press in an emergency. Staff locked unit doors at midnight. There were security staff based on site. There were bags in the waiting room with personal protective equipment.

Is the service effective?

Evidence-based care and treatment

The service provided treatment based on national guidelines and evidence of its effectiveness. However, guidance and policy was not always followed or checked by managers to ensure it was being followed.

The unit followed recommendations in line with the Royal College of Emergency Medicine ‘Unscheduled Care Facilities’ 2009. For example, we saw there were protocols in place to ensure the rapid transfer of patients to an emergency department should a patient deteriorate. However, there were concerns that patients were not getting an initial assessment to detect those at risk of deterioration or potentially serious conditions, this was not in line with trust policy.

Staff used the British National Formulary adults and children for reference around prescribing and pharmacology. The service carried out local audits in areas such as medication and infection control.

Care and treatment was delivered in line with National Institute of Health and Care Excellence (NICE) quality standards. For example, staff followed guidelines on antimicrobial stewardship and hand decontamination.

When necessary the service used a modified early warning score (MEWS) to decide the degree of illness in a patient. Staff had not yet adapted the National Early Warning Score (NEWS) introduced by the Royal College of Physicians to replace regional and local scores. Leaders told us that they thought this was due to the recent acquisition and were not aware of any plans to change this. The unit used the Paediatric Early Warning Score (PEWS) when needed to identify deteriorating children.

The unit had tools and pathways in place for children and adults that included the sepsis six. The sepsis six was developed by the Sepsis Trust and includes a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring which need to be completed by front line staff within one hour.

Nutrition and hydration

Snacks and drinks were available to patients in the minor injury unit. Staff could access food for patients if necessary.

Emergency Department Survey 2016

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.
In the CQC Emergency Department Survey, the trust scored 7.1 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the CQC Emergency Department Survey, the trust scored 6.6 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

We noted there were water coolers and vending machines for patients and relatives to use. Staff had access to a kitchen where they could make light snacks if a patient’s medical condition meant they needed to eat. Staff could obtain hot food from the acute medical unit at mealtimes if necessary, however as people were not in the minor injury department for long this was not usually necessary. We saw volunteers bring snacks and drinks around on a trolley.

Pain relief

Staff did not consistently record paediatric pain scores. The trust took part in the Royal College Emergency Medicines pain in children clinical audit 2017/18 where they did not meet the required percentage in any of the five standards set.

Emergency Department Survey 2016

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In the CQC Emergency Department Survey, the trust scored 5.0 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the CQC Emergency Department Survey, the trust score for the question “How many minutes after you requested pain relief medication did it take before you got it?” was suppressed.

The trust scored 7.8 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

There was a standardised pain assessment tool for staff to assess pain level. However, we found that paediatric pain scores were not always recorded. We reviewed nineteen paediatric medical
notes over two days and found that pain scores had not been recorded in thirteen instances. We raised our concerns and found that when we returned the following day pain scores were being recorded. We observed three assessments including one assessment of a child and saw that staff spoke to patients about pain relief and were empathetic towards pain.

The trust took part in the Royal College Emergency Medicines ‘pain in children’ clinical audit 2017/18. The audit was of children age five to 15 years arriving at the ED department in moderate or severe pain with a fractured elbow, forearm, wrist, ankle, tibia, fibula or femur. The purpose of the audit was to monitor documented care against published standards, departments were measured against the clinical standards of the Royal College in Emergency Medicine (RCEM) Quality in Emergency Care Committee but were asked to exclude patients who were only in mild pain. One hundred cases were reviewed (not site specific) findings showed that the trust did not meet the required percentage in any of the five standards set by RCEM. We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

There was an action plan in place in response to the ‘pain in children’ audit dated July 2018. Actions included introducing a new tool for patient/parent to monitor pain, to review Solihull data to investigate discrepancies between sites and to raise the issue with the clinical lead about the standard of assessment at Solihull Hospital.

**Patient outcomes**

There was improved outcomes for patients with an Achilles tendon rupture. Patients presenting with suspected renal colic had good analgesia administration, blood tests, urinalyses and radiological interventions.

The trust took part in national audits such as the Royal College of Emergency medicine (RCEM) moderate and acute asthma audit, severe sepsis and septic shock audit 2016/17 however, these did not apply to the minor injury unit (MIU).

The department kept a record of readmission rates. We looked at the data from March 2018 to September 2018 and how many patients had reattended within 7 days and saw that out of 24255 attendances there were 1104 readmissions (4.5%). These figures did not include patients who left the department before assessment or treatment or who refused treatment.

Data received from the trust showed that from March 2018 to September 2018 there were 2052 admissions and 134 emergency inpatient readmissions (6.5%).

The Solihull MIU unit had been involved in previous audits. Examples include the management of Achilles tendon ruptures completed by an extended scope physiotherapist. In the retrospective audit it was found that only 19.55 of patients were managed in accordance with trust guidelines. This led to the implementation of a dedicated rupture clinic in March 2017. Following this further audit showed that 100% patients were treated according to protocol, the patient pathway was improved and unnecessary appointments to trauma and orthopaedics.

The unit had also taken part in a Renal Colic Audit. The audit was to look at the standard of care given to patients presenting in moderate or severe pain with suspected renal colic in July/August 2017. Conclusions showed good analgesia administration, analgesia was given in accordance with local guidelines and great use if blood tests, urinalysis and radiological investigations and that appropriate referrals had been made. Areas for improvement included the need for further education regarding re-evaluation of pain and to review patients in a timelier manner.

**Competent staff**
Appraisal rates

No staff group met the trust target for appraisal rates which was 85%.

Solihull Hospital

From April 2017 to March 2018, 63.8 % of required staff within the emergency department at Solihull Hospital received an appraisal compared to the trust target of 85%. The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>26</td>
<td>40</td>
<td>65.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>44</td>
<td>68</td>
<td>64.7%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

No staff groups met the target of 85%.

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

Leaders at the unit told us that the appraisal rate had now improved to approximately 75%. We were unable to see any staff appraisals as part of our inspections as they were kept at Birmingham Heartlands Hospital. We saw that expired appraisals were discussed in the emergency medicine directorate meeting July 2018. It was asked that all staff push to get the appraisals completed.

The children’s nurse was allocated to Birmingham Heartlands Hospital one day a week to keep their skills updated. All emergency care practitioners were trained in minor injury. In order to complete the minor injury course staff were required to complete a competency document which had to be signed off by the student and an assessor. The competency document covered adults and children in areas such as conducting a physical examination of the client’s head, neck and facial injuries, discharging a client to an appropriate multidisciplinary team, demonstrating knowledge of wounds and wound healing and demonstrating knowledge concerning particular variation in interpretation of children’s x rays.

There were processes in place for the induction of agency staff, however checklists to show information had been given to staff were not fully completed. There was a written process in place for the induction of agency staff, alongside a procedure for the induction of temporary staff. The guidance listed the information to be given such as fire procedures, IT access, policy location and lines of responsibility. There was a section for staff to sign to confirm they had received the information. Recruitment services provided the trust with details of staff experience including professional clinical experience and employment history and on numbers. We reviewed a signed, completed checklist and found areas had not been covered such as incident reporting, duties and responsibilities, the resuscitation policy and the bleep system.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. GP’s, emergency nurse practitioners and other healthcare professionals supported each other to provide good care.

There were good working relationships between multidisciplinary teams. We saw that GP’s, consultants, emergency care practitioners and health care assistants worked together well.
The team worked closely with staff on the acute medical unit (AMU) when patients needed further treatment or assessment; this was also true of the adjoining x ray department.

The rapid assessment team for patients with mental health needs was based nearby. Staff could refer and receive a response easily if needed.

An older peoples’ assessment service (OPAU) was available. Staff from the service worked closely together with the staff on MIU to assess patient’s needs.

Pharmacists and staff from the hospitals safeguarding team visited the unit regularly to give staff advice and support. Physiotherapists supported the review clinics alongside a doctor.

**Seven-day services**

The minor injury unit was open 24-hours a day, seven days a week. Supporting services had varied operating times.

The Minor injury unit was open 24 hours a day, seven days a week.

An ambulatory care service ran from 8am to 8pm seven days a week.

There was medical cover each day until 10pm, after this staff could access support from medical staff on the AMU. Staff could transfer sick patients to the Birmingham Heartlands Hospital Emergency Department 24-hours a day.

There was a rapid assessment team (RAID) for patients presenting with mental health needs, the team were available from 8am to 8pm with on call cover out of hours.

The hospital pharmacy department was open seven days a week with a pharmacist available Monday to Friday. At weekends staff could contact an on-call pharmacist if needed.

The older people’s assessment and liaison service saw patients until 4pm each day.

**Health promotion**

Staff recognised when people required further support and would refer them to other services who could provide additional support or further assessment such as the older people’s assessment and liaison service. There were posters on display around substance misuse and support for alcohol misuse. There was a range of leaflets providing information on different health conditions displayed in the waiting room area.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Staff understood their roles and responsibilities under the Mental Health act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental health and those who lacked capacity to make decisions about their care.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust combines safeguarding level 2, mental capacity and deprivation of liberty (DoLS) training.

**Solihull Hospital**
A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for qualified nursing staff in urgent and emergency care at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>45</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for this training module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in urgent and emergency care at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>1</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for this training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff gained verbal consent from patients and understood legislation around mental capacity.

A consent for treatment policy was in place which set out agreed processes for obtaining consent prior to examination and treatment. Staff followed policy and demonstrated or could explain the consent and decision-making requirements of legislation and guidance around mental capacity. We saw staff gained verbal consent from patients prior to delivering any care and treatment. There were no patients that required a mental capacity assessment at the time of our inspection.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Friends and Family test performance

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to
The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was slightly worse than the England average from July 2017 to June 2018.

**A&E Friends and Family Test performance - University Hospitals Birmingham NHS Foundation Trust**

![Graph showing A&E Friends and Family Test performance for University Hospitals Birmingham NHS Foundation Trust compared to England average.]

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from August 2017 to March 2018.

**A&E Friends and Family Test performance - Heart of England NHS Foundation Trust**

![Graph showing A&E Friends and Family Test performance for Heart of England NHS Foundation Trust compared to England average.]

The trust provided us with updated information broken down by site from April 2018 to August 2018

England averages for April – Aug 18

<table>
<thead>
<tr>
<th>Month</th>
<th>England</th>
<th>Solihull</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Response rate</td>
<td>Recommended</td>
</tr>
<tr>
<td>Apr 18</td>
<td>12.9%</td>
<td>87%</td>
</tr>
<tr>
<td>May 18</td>
<td>12.4%</td>
<td>87%</td>
</tr>
<tr>
<td>Jun 18</td>
<td>13.0%</td>
<td>87%</td>
</tr>
<tr>
<td>Jul 18</td>
<td>12.8%</td>
<td>87%</td>
</tr>
<tr>
<td>Aug 18</td>
<td>12.9%</td>
<td>88%</td>
</tr>
</tbody>
</table>

We observed six patient assessments and found staff took time to interact with people who used the service and that they treated them with kindness and respect.

Staff were sensitive and empathetic towards patients who were in pain and treated them with compassion. We saw staff speaking to patients who were anxious in a calming manner and spoke to them by name. Patients comments included staff were friendly and they made them feel welcome.

Emergency care practitioners and health care assistants ensured that people’s privacy and dignity was respected during assessments by closing curtains and doors. They introduced themselves to patients.

However, in the reception area people queued close together when booking in. People provided confidential details such as addresses, dates of birth and the reasons they had come to the unit. Reception staff did not ask patients waiting to respect peoples personal space.
Staff were aware of peoples’ religious needs and knew what services were on site if they needed to direct patients such as a prayer room.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

We saw that staff understood the impact that a person’s care, treatment or condition had on people’s wellbeing. Staff ensured that patients were given information on what was happening such as what they were doing when they took someone’s blood pressure and giving people options around returning to the service for review.

Staff told us they would spend longer with patients if needed and could give an example of when this had happened.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

Staff listened, gave good explanations, engaged with patients and answered their questions. They spoke to children in language they could understand. Staff checked patient’s levels of understanding and explained what would happen next. Staff gave patients updates on when they would likely be seen.

**Emergency Department Survey 2016**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust scored worse than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>2.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>member of medical or nursing staff to help you?</td>
<td></td>
<td>as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>another will say something quite different. Did this happen to you in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your care and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>while you were in the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>treatment, did a doctor or nurse discuss them with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>department, did a member of staff help to reassure you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>of your tests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>were to take at home in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to</td>
<td>4.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>watch out for?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>activities, such as when to go back to work or drive a car?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account</td>
<td>4.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>when you were leaving the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>your illness or treatment to watch for after you went home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment after you left the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust scored about the same as other trusts for 23 of the 24 Emergency Department Survey questions relevant to the caring domain. The score for the remaining question was suppressed due to low figures.
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Were you feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q29. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>No score</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Q32. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. Did a member of staff tell you about what</td>
<td>5.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>danger signals regarding your illness or treatment to watch for after you went home?</td>
<td></td>
<td>as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Is the service responsive**

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

Volunteers were based outside the unit. Volunteers were available to give people directions and provide drinks and snacks. The minor injury unit provided a 24-hour service for patients with minor injuries.

There were parking facilities for patients and their relatives. We saw that reception staff offered patients choices of dates and venues for follow up appointments.

The facilities and premises were mainly appropriate for the services that were planned and delivered. There were adequate seating spaces available for patients who were waiting to be seen. However, adults waiting for an x-ray waited in the same room as the children’s waiting area.

Leaders told us they attended meetings with the local clinical commissioning group on behalf of the trust.

There was still some red signage in Solihull that showed the minor injury department was an Emergency Department this could cause some confusion. This was highlighted in the earlier inspection. Leaders told us they were working with the council to rectify the situation and had sent out letters out to local schools to ensure people knew that there was no emergency department at the trust. The Minor Injury Department was well signposted.

Meeting people’s individual needs

There was limited support and accessible information for people living with a learning disability or whose first language was not English.

Emergency Department Survey 2016

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust scored about the same as other trusts for all the three Emergency Department Survey questions relevant to the responsive domain.
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust scored better than other trusts for one of the three Emergency Department Survey questions relevant to the responsive domain. The trust scored about the same as other trusts for the remaining two questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.5</td>
<td>Better than other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

A translation service was available to patients and staff if needed. Reception staff told us patients would often choose to use their mobile phones to translate.

The trust had pathways in place to ensure patients individual medical needs were met, staff had good awareness of these. Services such as the acute medical unit and x-ray department were next to the unit so patients did not have to go far for follow up support. An ambulatory care service ran at the trust.

There was an older peoples' assessment and liaison service (OPAU) that would visit the unit to carry out assessments on older people if additional needs were found. The service could look at patient’s medications, make plans to transfer the patient to the medical day hospital. Staff told us they would write to the patients GP if they had any concerns around a patient living with dementia.

The unit could access the mental health team who could give support to people around their mental health needs.

There was a room next to the nurse’s station with lots of toys available for children.

A consultant led review clinic ran within the department Monday's, Tuesday's, Thursday’s and Friday’s from 10am to 12 noon. Emergency care practitioners and a physiotherapist supported the clinic.

Wheelchairs were available if needed and all areas were wheelchair accessible. There was a disabled pull cord in the toilets if patient with a disability needed to call for aid.

There were contact details for support services such women’s aid and a substance abuse outreach service on display in waiting areas.

Staff told us that they would give extra time to patients living with a learning disability or dementia and to those patients with communication difficulties. However, they did not have any aids or
communication tools they could use as support.

There were no leaflets on display for patients whose first language was not English. We asked staff about this and they told us that they had not got any that they knew of.

Access and flow

Median time from arrival to treatment (all patients)

Waiting times from referral to treatment were slightly worse than the national average with patients waiting more than one hour (median time) from May 2018 to July 2018.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust submitted two separate sets of figures from April to July 2018, one for Queen Elizabeth Hospital and a combined figure for the other trust sites.

Queen Elizabeth Hospital did not meet the standard over the 12-month period from July 2017 to June 2018. The trust also performed worse than the England average across the entire reporting period.

In April 2018 the other sites met the standard and had a median time lower than the England average by two minutes. From May 2018 onwards these sites reported times higher than both the standard and the national average.

The trust has submitted the below figures for the median time from arrival to treatment for August 2017 to March 2018:

<table>
<thead>
<tr>
<th>Month</th>
<th>University Hospitals Birmingham NHS Foundation Trust</th>
<th>Former Heart of England NHS Foundation Trust sites</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>65</td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>Sep-17</td>
<td>73</td>
<td></td>
<td>58</td>
</tr>
<tr>
<td>Oct-17</td>
<td>78</td>
<td></td>
<td>59</td>
</tr>
<tr>
<td>Nov-17</td>
<td>81</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Dec-17</td>
<td>63</td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>Jan-18</td>
<td>84</td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>Feb-18</td>
<td>85</td>
<td></td>
<td>61</td>
</tr>
<tr>
<td>Mar-18</td>
<td>85</td>
<td></td>
<td>64</td>
</tr>
<tr>
<td>Apr-18</td>
<td>76</td>
<td>58</td>
<td>60</td>
</tr>
<tr>
<td>May-18</td>
<td>72</td>
<td>68</td>
<td>61</td>
</tr>
<tr>
<td>Jun-18</td>
<td>76</td>
<td>64</td>
<td>62</td>
</tr>
<tr>
<td>Jul-18</td>
<td>90</td>
<td>73</td>
<td>64</td>
</tr>
</tbody>
</table>

Data from April 2018 was still being submitted using the trust code for Heart of England NHS Foundation Trust up to (and including) July 2018.
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In August 2017 the trust performed better than the standard but above the England average. However, from September 2017 to March 2018 the trusts performance was fairly stable at a level above both the standard and England average.

(\textit{Source: NHS Digital - A&E quality indicators})

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The trust did not meet the standard for the percentage of patients admitted, transferred or discharged within four hours from August 2017 to July 2018 and performed worse than the England average most months except in December 2017.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018 the trust failed to meet the standard and performed worse than the England average in every month, other than in December 2017 when trust performance exceeded the average.
Four-hour target performance - University Hospitals Birmingham NHS Foundation Trust

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust failed to meet the standard and performed worse than the England average.

Four-hour target performance - Heart of England NHS Foundation Trust

(Source: NHS England - A&E Waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

The trust’s monthly percentage of patients waiting more than four hours from the decision
to admit until being admitted was varied. Some months they performed better than the England average and sometimes they performed worse.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average in August 2017 and from December 2017 to March 2018. From September to November 2017 and from April 2018 onwards the trust’s performance was worse than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - University Hospitals Birmingham NHS Foundation Trust

The following table shows the monthly number of patients waiting more than four hours to admission:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>177</td>
</tr>
<tr>
<td>Sep-17</td>
<td>491</td>
</tr>
<tr>
<td>Oct-17</td>
<td>590</td>
</tr>
<tr>
<td>Nov-17</td>
<td>443</td>
</tr>
<tr>
<td>Dec-17</td>
<td>262</td>
</tr>
<tr>
<td>Jan-18</td>
<td>782</td>
</tr>
<tr>
<td>Feb-18</td>
<td>639</td>
</tr>
<tr>
<td>Mar-18</td>
<td>702</td>
</tr>
<tr>
<td>Apr-18</td>
<td>1,889</td>
</tr>
<tr>
<td>May-18</td>
<td>1,850</td>
</tr>
<tr>
<td>Jun-18</td>
<td>1,689</td>
</tr>
<tr>
<td>Jul-18</td>
<td>1,755</td>
</tr>
</tbody>
</table>
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Heart of England NHS Foundation Trust

The following table shows the monthly number of patients waiting more than four hours to admission:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>1,218</td>
</tr>
<tr>
<td>Sep-17</td>
<td>1,374</td>
</tr>
<tr>
<td>Oct-17</td>
<td>1,500</td>
</tr>
<tr>
<td>Nov-17</td>
<td>1,483</td>
</tr>
<tr>
<td>Dec-17</td>
<td>2,089</td>
</tr>
<tr>
<td>Jan-18</td>
<td>2,453</td>
</tr>
<tr>
<td>Feb-18</td>
<td>2,339</td>
</tr>
<tr>
<td>Mar-18</td>
<td>2,363</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E SitReps).

Number of patients waiting more than 12 hours from the decision to admit until being admitted

University Hospitals Birmingham NHS Foundation Trust
We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Over the 12 months from August 2017 to July 2018, two patients waited more than 12 hours from the decision to admit until being admitted. These occurred in August 2017 and May 2018 with one patient waiting more than 12 hours in both months.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From September 2017 to August 2018, one patient waited more than 12 hours from the decision to admit until being admitted. This occurred in February 2017.

(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

The percentage of patients that left the trusts urgent and emergency cares services before being seen for treatment was worse than the England average between August 2017 to July 2018.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From August 2017 to July 2018 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was worse than the England average, with null returns from the trust in April – July 2018.
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In August 2017 and September 2017, the monthly percentages of patients that left the trust’s urgent and emergency care services before being seen for treatment were worse than the England average, with the rate falling to just below the England average in October 2017.

From November 2017 to March 2018 the trust submitted zero returns, which may indicate a data collection issue.

Percentage of patients that left the trust’s urgent and emergency care services without being seen - Heart of England NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)
The median time for total time spent in A&E was higher than the England average from April to July 2018.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust submitted two separate sets of figures for the total time spent in A&E per patient from April to July 2018, one for Queen Elizabeth Hospital and a combined figure for the other trust sites.

From August 2017 to July 2018 the monthly median total time in A&E for all patients at Queen Elizabeth Hospital was higher than the England average. Similarly, the median time for the other trust sites was higher than the England average from April to July 2018.

<table>
<thead>
<tr>
<th>Month</th>
<th>Queen Elizabeth Hospital</th>
<th>Other Sites</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>170</td>
<td></td>
<td>144</td>
</tr>
<tr>
<td>Sep-17</td>
<td>176</td>
<td></td>
<td>148</td>
</tr>
<tr>
<td>Oct-17</td>
<td>185</td>
<td></td>
<td>148</td>
</tr>
<tr>
<td>Nov-17</td>
<td>186</td>
<td></td>
<td>152</td>
</tr>
<tr>
<td>Dec-17</td>
<td>174</td>
<td></td>
<td>159</td>
</tr>
<tr>
<td>Jan-18</td>
<td>191</td>
<td></td>
<td>153</td>
</tr>
<tr>
<td>Feb-18</td>
<td>193</td>
<td></td>
<td>156</td>
</tr>
<tr>
<td>Mar-18</td>
<td>195</td>
<td></td>
<td>160</td>
</tr>
<tr>
<td>Apr-18</td>
<td>184</td>
<td>159</td>
<td>149</td>
</tr>
<tr>
<td>May-18</td>
<td>172</td>
<td>161</td>
<td>148</td>
</tr>
<tr>
<td>Jun-18</td>
<td>178</td>
<td>158</td>
<td>148</td>
</tr>
<tr>
<td>Jul-18</td>
<td>191</td>
<td>166</td>
<td>150</td>
</tr>
</tbody>
</table>

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust’s monthly median total time in A&E for all patients was higher than the England average.

Median total time in A&E per patient - Heart of England NHS Foundation Trust
Patients could access the service at a time suitable for them, patients could walk into the unit without a referral.

The ambulatory care service provided in reach to the medical assessment unit (MAU) and the minor injury service. If staff saw a patient was suitable for the service they would approach them and take them to the service.

Many pathways involved patients being referred to the acute medical unit for further assessment, Staff told us that patients sometimes needed to wait longer if the acute medical unit (AMU) was busy; this meant patients needing further assessments could be delayed at busy times.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from results.

**Summary of complaints**

From April 2017 to March 2018 there were 179 complaints about urgent and emergency care services across the trust as a whole. The trust took an average of 38 working days to investigate and close complaints. This is not in line with their complaints policy, which stated complaints should be resolved within 30 working days.

Of the 14 complaints still open at the time of reporting all had been open longer than the trust target of 30 working days, the longest being open for 236 working days.

A breakdown by site is below:

- Queen Elizabeth Hospital: There were 100 complaints, the main themes were clinical treatment with 31 complaints (31%), staff with 25 complaints (25%), patient care including nutrition / hydration with 14 complaints (14%) and communications with 14 complaints (14%)

- Birmingham Heartlands Hospital: There were 43 complaints, the main themes were all aspects of clinical treatment with 24 complaints (55.4%), attitude of staff with eight complaints (18.6%) and admissions, discharge and transfer arrangements with five complaints (12.1%)
- Good Hope Hospital: There were 22 complaints, the main themes were all aspects of clinical treatment with 12 complaints (54.5%) and admissions, discharge and transfer arrangements with five complaints (22.2%)

- Solihull Hospital: There were 11 complaints, the main theme was all aspects of clinical treatment with five complaints (45.5%)

- Unspecified location: Three complaints did not have the hospital site specified, two of these related to all aspects of medical care and one related to ‘Other’.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2017 to March 2018 there were 148 compliments within urgent and emergency care.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>98</td>
<td>66.2%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>24</td>
<td>16.2%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>17</td>
<td>11.5%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>9</td>
<td>6.1%</td>
</tr>
<tr>
<td>Total</td>
<td>148</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

There were ‘tell us what you think’ leaflets visible around the department and there were processes in place to investigate complaints. Leaders told us they tried to manage complaints face to face. Patients could contact the patient advice and liaison service (PALS) if they wished to make a formal complaint.

We reviewed three responses to complaints at the unit between January 2018 and July 2018 and found they contained an apology, explanations, details of the care the patient had received, actions the trust would take and what to do if they were not satisfied with the outcome of the complaint such as contacting the Parliamentary and Health Service Ombudsman.

Complaints were not a standard agenda item in emergency department practitioner meetings. We reviewed three sets of minutes from emergency care practitioner’s meetings dated between December 2017 and September 2018 and saw that complaints were not discussed. We were not therefore, assured learning from complaints was shared amongst the MIU team.

Is the service well-led?

Leadership

There was a clear leadership structure in place, leaders worked closely together and rotated across hospital sites. The trust had several divisions. The MIU sat under division three which also covered the acute medical unit, stroke and respiratory unit. The division had a clear structure which included division and deputy divisional directors, divisional directors and matrons. The department also had a clinical lead who worked across sites as did the matron. Reception staff had a different management team.
The service had a manager and a matron, the matron was new to the post but not to the trust. The two leads worked together well and were visible to staff.

Band seven emergency care practitioners had overall responsibility for the shift and worked with great autonomy. There were photographs of the executive team and who they were at the nurses’ station.

**Leaders did not always have enough oversight to recognise risks within the department.** For example, the risk we identified around patients not receiving initial assessments to ensure they were not deteriorating had not been recognised by leaders. However, during the inspection we raised our concerns with leaders about people not receiving an initial assessment. The executive team, alongside the clinical lead acted immediately to ensure the risk was removed. We were able to see positive changes had been implemented when we returned to the unit unannounced a week later.

**Staff feedback on the leadership team was varied with four staff members telling us they did not feel supported, that leaders were not approachable and that they were not listened to; they also commented on low staff morale.** There were concerns that when issues were raised they were not always acknowledged or addressed.

Five staff raised concerns to us that there was no doctor at night and that they felt vulnerable and concerned about this; their anxiety about this was clear. However, staff concerns in relation to this had not been addressed sufficiently to ease their anxiety. Staff were also still feeling vulnerable at night due to recent incidents when patients had behaved in a threatening manner towards staff impacting on how safe they felt when left alone. This was despite actions being taken by leaders to address the issues.

**Vision and strategy**

**The trust had a vision for what it wanted to achieve and strategic priorities in place. However workable plans had not yet been developed or implemented.** Staff were aware of the trust’s vision and values and demonstrated them when providing care and support. Staff communicated openly and treated patients with dignity, respect and professionalism.

Senior leaders could articulate their vision of what future services would look like across the trust. There were strategic priorities in place which included reviewing options for the minor injury unit and GP services. Leaders spoke of changes due to the acquisition which had led to some delays in implementation. The ambition for 2020 was that the service and facilities met the needs and demand of the local population.

**Culture**

**Staff felt supported by colleagues and worked with a lot of autonomy. Behaviour that was inconsistent with the trust’s values was addressed.** Staff spoke of a supportive culture amongst colleagues, having a lot of autonomy and told us they enjoyed what they did. Staff worked well together as a team and were clear about their roles and responsibilities.

Staff communicated openly with patients; staff provided assessments that centred on the needs of the patient. However, improvement was needed to support people with learning difficulties and whose first language was not English.

Expectations around professional accountability were set out and communicated in staff meetings. For example, in the minutes from the emergency care practitioner meeting dated September 2018 it was communicated that there was an expectation that staff arrived to work on time, that they adhered to the dress code and they were professional at all times.
There were processes in place for behaviour that was inconsistent with staff values such as being late on a shift or being unprofessional this would lead to performance notices, reflection, informal discussions and a notice put on file should any further concerns arise which needed a formal response. Professional standards were discussed in quality and safety meetings.

**Governance**

**Monthly directorate meetings took place. Meetings were attended by a variety of professionals including clinical leads, consultants and matrons.** Safety and governance was discussed in these meetings. Other items on the agenda included staffing, mandatory training, finance and leadership.

Division 3 quality meetings took place every three months and were attended by the clinical lead. Divisional governance reports were discussed and included incidents, duty of candour, risks, Root Cause Analysis (RCA’s) and staff vacancies.

Emergency care practitioners, managers and clinical leads met quarterly to discuss areas such as responsibilities, training, education and concerns.

**Matrons had their own meetings across hospital sites so they could share learning, safety alerts and any other relevant information.** Leaders told us that these meetings were informal so minutes were not available and were not formally recorded.

**Management of risk, issues and performance**

There was no clear policy around children who were not acutely unwell attending the unit at night. Leaders told us they did not see children at night; however, data showed and staff told us that children were still present.

Leaders told us that the department did not see children at night and that the risk of having no doctor at night were mitigated due to this; however, staff told us children still presented at the unit. We reviewed data from the trust on the amount of paediatric attendances at Solihull MIU July to September 2018 and saw that 452 children had attended between the hours of 8pm and 8am. We reviewed the emergency department standard operational policy dated July 2018 that also covered the minor injury unit and found that the trusts position around assessing children who were not acutely unwell at night was unclear. The department had been trying to get the message out that the department was not an emergency department. We saw letters had been sent out to schools to this effect.

Serious incidents were discussed in the safety and governance slot of the monthly emergency department directorate meetings. Risky business forums took place to discuss risky business at the trust. We reviewed three sets of minutes from the forum and found they contained issues, action points, trust alerts and learning from inquests.

**Risks were discussed during emergency nurse practitioner meetings. There was a divisional risk register in place.** We reviewed several sets of minutes and found that risks around inappropriate referrals and security at night had been discussed.

There was an emergency care risk profile in place for the division which included risks around the emergency department and medicine core services across sites. The profile was rag rated (red, blue, yellow, amber and green and white). We reviewed the risk profile dated October 2018 and found that there were no risks in relation to the minor injury unit at Solihull.

**The divisional risk register did not contain all the risks from the department. The unit did not have its own risk register.**
On occasions where risks had been identified and verbalised by leaders these were not recorded on the divisional risk register. For example, it had been found in the Royal College of Emergency Medicines (RCEM) pain in children audit 2017/18 that none of the five standards had been met and an action plan was in place. However, we reviewed the division 3 emergency care risk profile and found this was not recorded. Additionally, there was nothing around children who attended the department at night or around security of patient records.

**Systems were in place to deal with challenging behaviour when it occurred within the unit.** If a patient was aggressive they would be issued with a red or yellow card. A red card meant they could not return to the unit and a yellow card would alert the patient that their behaviour was unacceptable. The trust also employed security staff who staff could contact if required.

**Information management**

**Staff could access paper records and electronic systems in order to carry out their role.** Staff used paper records to record information following an assessment. Clinicians had access to electronic systems such as test results. Reception staff booked patients in electronically. Staff linked with the safeguarding team and health visitor if they needed to access safeguarding information about a child. Staff could access computers when needed.

**Engagement**

The trust engaged well with patients, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The department engaged with patients and staff. They did this through the friends and family test and a hospital newspaper that was readily available. The newspaper ‘news@UHB’ contained various hospital related topics in relation to Solihull Hospital.

Matrons, managers and emergency care practitioners attended regular meetings. However, health care practitioners were not included in these.

**Learning, continuous improvement and innovation**

**Systems were put into effect to improve when concerns were identified during the inspection. The trust held awards to recognise staff contribution.**

The building healthier lives awards aimed to recognise staff who were building healthier lives for people. We met a member of staff who had been nominated for this.

Staff ideas had been implemented for example, the implementation of a safety checklist that staff signed daily. Staff were encouraged to develop by attending regular training.

There had been recent security issues at night. Changes had been made as a result and were ongoing, for example we saw that there was CCTV monitoring at the nurses’ station and emergency buttons under desks that staff could press in an emergency that would sound an alarm to alert other staff.
University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

The medical care service at University Hospital Birmingham NHS Foundation Trust provides care and treatment for a wide range of specialties including:

- cardiology
- colorectal
- diabetes
- endoscopy
- infectious diseases
- neurology
- oncology
- renal
- respiratory
- stroke

There are 1,579 medical inpatient beds located across 56 wards plus 17 beds on a multi-specialty ward for private patients at Queen Elizabeth hospital.

The trust also provides acute medical care at Birmingham Chest Clinic, Castle Vale Renal Dialysis Centre and Runcorn Road Renal Dialysis Centre.

(Source: Routine Provider Information Request (RPIR) – Sites – All tab)

At Queen Elizabeth Hospital acute medicine is delivered through a 74-bedded consultant-led clinical decision unit which accepts referrals from the emergency department and the single point of access unit. The unit has a four-bedded level two facility catering for patients with multiple organ failure. The ambulatory medical clinic is open 24 hours a day, seven days a week and manages approximately 7,000 patients per year.

(Source: Acute Provider Information Request (RPIR) – Context acute QE tab)

Specialist elderly care services operate across the Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital sites with a frailty ambulatory emergency care available on the medical day units (MDU) at both Birmingham Heartlands Hospital and Good Hope Hospital. Teams are multi-professional and assess patients in the emergency department who are suitable to be managed in the MDU as an ambulatory patient. The team also carry out comprehensive geriatric assessments, instigate and carry out appropriate diagnostics and interventions with the
aim to return the patient to their usual place of residence with or without support services. At Solihull Hospital ambulatory care is provided via the frailty advice and support team who operate out of the medical day unit.

Additionally, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital provide ortho-geriatric support to the trauma and orthopaedic wards and all geriatricians run afternoon outpatient clinics.

There is also a well-established dementia and delirium team which works across all of the complex elderly care wards at all three sites and aims to educate staff, patients and carers on dementia and delirium care.

(Source: Acute Provider Information Request (RPIR) – Context acute HGS tab)

The medical care service at the trust provides care and treatment for ten specialities across four sites; Queen Elizabeth Hospital Birmingham, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital. The trust had 1,579 inpatient medical beds across the four sites, with 155 beds available at Solihull Hospital.

(Source: Routine Provider Information Request (RPIR) – Sites – All tab)

<table>
<thead>
<tr>
<th>Solihull Hospital</th>
<th>Acute medical unit assessment</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute medical unit short stay</td>
<td>20</td>
</tr>
<tr>
<td>Coronary care unit</td>
<td>Cardiology</td>
<td>4</td>
</tr>
<tr>
<td>Ward 8</td>
<td>Stroke and general medicine flex ward</td>
<td>24</td>
</tr>
<tr>
<td>Ward 17</td>
<td>Cardiology</td>
<td>21</td>
</tr>
<tr>
<td>Ward 19</td>
<td>Respiratory</td>
<td>27</td>
</tr>
<tr>
<td>Ward 20A / CAU</td>
<td>Elderly care</td>
<td>20</td>
</tr>
<tr>
<td>Ward 20B</td>
<td>General medicine</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td></td>
<td>155</td>
</tr>
</tbody>
</table>
**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Data shows that in most cases, Solihull Hospital met the trust target of 90% completion rate in mandatory training, for nursing staff and allied professionals, in eight out of 12 subjects. Three of the four that did not meet the target were less than 1% below target and the fourth was below 3% from target.

Locally, we saw that all of the medical wards that we visited were above the 90% target for mandatory training and that ward managers monitored the levels to achieve the target. We saw plans on each ward that indicated when staff would be out of date and any future training that had been planned.

We saw examples where staff had all completed mandatory training. Staff on ward 19 had a 100% completion rate for mandatory training and this was displayed in the manager’s office. Sepsis management and dementia awareness training were not included in the mandatory training programme and we saw that there was inconsistency in providing training in these subjects. Senior staff told us that there would be a review of all training for both nursing and medical staff across the Solihull Hospital site.

Mandatory training provided for nursing staff and allied professionals at Solihull Hospital is listed below and included, fire safety, manual and patient handling, basic life support, Health and safety, infection prevention and control and corporate induction.

Following UHBs acquisition of HEFT, work was ongoing to align systems and processes to monitor and follow-up compliance with mandatory training.

**Solihull Hospital**

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines management</td>
<td>132</td>
<td>133</td>
<td>99.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>134</td>
<td>136</td>
<td>98.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>134</td>
<td>136</td>
<td>98.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>133</td>
<td>136</td>
<td>97.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>130</td>
<td>136</td>
<td>95.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management</td>
<td>129</td>
<td>136</td>
<td>94.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>129</td>
<td>136</td>
<td>94.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>124</td>
<td>136</td>
<td>91.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>122</td>
<td>136</td>
<td>89.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>121</td>
<td>135</td>
<td>89.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>121</td>
<td>136</td>
<td>89.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
In medicine, the hospital had an overall training compliance rate of 75.5% for medical staff. The trust’s 90% completion target was met for four of the 12 mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in medicine at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>62</td>
</tr>
<tr>
<td>Medicines management</td>
<td>62</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>61</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>59</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>59</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>51</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>46</td>
</tr>
<tr>
<td>Fire safety</td>
<td>46</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>41</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>38</td>
</tr>
<tr>
<td>Information governance</td>
<td>34</td>
</tr>
<tr>
<td>Waste management</td>
<td>31</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall training compliance rate of 93.8% for qualified nursing staff. The trust’s 90% completion target was met for eight of the 12 mandatory training modules for which qualified nursing staff were eligible.

The service provided mandatory training in key skills to all staff, however, medical staff across Solihull Hospital only achieved the trust target in four out of the 12 subjects. Four subjects were below 70% compared to the trust target.

Mandatory training provided for medical at Solihull Hospital is listed below but included, fire safety, manual and patient handling, basic life support, Health and safety, infection prevention and control and corporate induction.

We saw plans to ensure that staff were trained in key areas and from April 2018, each ward we visited had information about staff training, including planned training dates.

Safeguarding

Though the trust has reported figures for safeguarding level 1 training, it should be noted that the trust has not designated this as mandatory training.

(Source: Routine Provider Information Request (RPIR) – Training tab)
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.

Safeguarding teams were managed by the head nurse for safeguarding who reported to the chief nurse who was the executive lead for safeguarding, providing oversight of safeguarding arrangements across the trust.

Following UHB acquisition of HEFT, safeguarding arrangements were to be reviewed and revised to meet the requirements of the new organisation thus aiming to improve safeguarding practice across the trust.

Staff demonstrated a good understanding of the safeguarding policies, procedures and what to do should a safeguarding situation arise. Staff could tell us of examples where they had raised a safeguarding concern with the trust team who took it forward. Female genital mutilation (FGM) was covered within the level 3 safeguarding training, there were also training modules available for staff to access via the online training package, which included female genital mutilation (FGM) information. During the last 12 months, a trust wide monitoring system for FGM has been set up to implement the FGM Risk Indicator System (RIS). This is a system that flags children deemed to be at high risk of FGM.

Patients at risk of suicide or self-harm were referred to the rapid access interface and discharge (RAID) team. We saw referrals could be verbal, for emergency access, but would be followed with a formal referral to the team. The RAID team were supportive and could be accessed for advice at any time.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>133</td>
<td>133</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>135</td>
<td>136</td>
<td>99.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In medicine, the hospital had an overall safeguarding training compliance rate of 99.6% for qualified nursing staff. The trust’s 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible. Only one member of staff had not completed one of the safeguarding training modules.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in medicine at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>60</td>
<td>65</td>
<td>92.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
In medicine, the hospital had an overall safeguarding training compliance rate of 84.6% for medical staff. The trust’s 90% completion target was met for one of the two safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We saw plans to ensure that staff were trained in safeguarding and from April 2018, each ward we visited had information about staff training, including planned training dates.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All areas that we visited appeared visibly clean and tidy. We saw that cleaning was taking place throughout the day and staff followed a schedule to ensure that all areas were routinely cleaned. Specific areas or equipment was cleaned upon request and between patients when a patient had been discharged or moved to another area.

We saw that staff followed guidelines for hand hygiene and washed their hands or used sanitising gel, between visits to patients and before commencing any care with a patient.

We saw hand hygiene audit results on wards. All results were above 90% compliant and on some areas, we saw that 100% had been achieved. For example, ward 17 had been lower in February and March 2018, but increased compliance from April to September 2018, with results at 100% from June to September 2018.

Infection prevention and control (IPC) link nurses were available on all wards we visited and there were notices for staff with instructions on how to escalate IPC issues.

Staff and visitors could access hand sanitising gel at the entrances and at various points within ward areas. The dispensers for the gel were all in working order and had sufficient supply of gel available for anyone to use.

We saw staff wearing personal protective equipment (PPE) appropriately when caring for patients and changing it before moving to another patient. Staff were observed washing hands or using hand sanitiser between patients.

There were notices on wards to remind staff about the use of PPE and giving clear instructions to staff about infection, prevention and control.

Appropriate precautions were in place including the use of PPE, where it had been identified patients might present a risk of spreading infections to others. During this inspection we observed one patient nursed in isolation. Processes to protect the patient and others was robust and followed by all staff. There was a sign on the door to indicate IPC precautions were in place and the door was closed. We saw IPC audit results for the oncology day unit which were consistently 100% compliant. There were closed intravenous (IV) systems in place with minimum risk to staff or patients. Closed IV catheter systems offer protection to the clinician inserting the device, reducing the risk of a needlestick injury. The main risk from a needlestick injury is the potential exposure to infections such as blood-borne viruses (BBV).
On some wards there were chairs stacked in the main corridor. These were used for people visiting patients and would be returned by staff during the day. Although we did not observe the process we were told that the chairs would be cleaned before being stacked ready for use.

On every ward we visited, we saw thank you cards and messages displayed for staff and visitors to see. Some wards had the messages located within cabinets to help prevent cross contamination and because they could not be cleaned as part of the IPC and hygiene schedule. Staff told us this had been done to help prevent IPC issues arising.

We saw on ward 17 that for two days there had not been a signature done to say that the commodes and trolley had been cleaned. The nurse in charge investigated and reported that they had been cleaned but the member of staff had not completed the note with a signature.

Patients were screened for bacterial infections such as MRSA, on admission to wards. Infection, prevention and control (IPC) lead nurses were available to support staff with IPC concerns. Monthly audits were done to monitor IPC across the wards. Results and action plans were shared with staff to indicate areas of improvement.

We saw that infection rates were comparable to other similar trusts and a programme for 2017 – 2018 had been set up to improve the IPC management across all sites. The post 48-hour MRSA bacteraemia-free period, to the end of March 2017 was 2520 days for Solihull hospital. This was better than the other hospitals across the trust. Recent data was not available to us for the post acquisition period, however, we were told that this information was being reviewed across the trust.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

There was a bay closed to patients because it was being prepared for a deep clean. Senior staff told us that this would be done periodically to compliment the normal level of cleaning that the hospital provided. In this case the bay was being prepared ready for use as an escalation area, if required during the coming winter period.

We reviewed equipment in all areas we visited, which included pressure relieving mattresses, hoists, blood pressure machines, electrocardiogram (ECG) machines, defibrillators. Equipment we reviewed was maintained in accordance with a maintenance plan that the estates department managed. We saw that electrical equipment was tested in accordance with regulations and stickers were used to indicate the date of testing. Staff told us that access to this equipment was good and there was enough available for them to use.

Daily checks were done and signed for on resuscitation trolleys that we looked at, and labels were attached with information about the appropriate testing and date of completion for each item.

We saw that the service used pre-sealed sharps bins to safely dispose of needles and other sharp implements. These bins were identified using a bar code system to ensure monitoring and disposal or replacement processes were safe and efficient.

We saw results for environmental audits, which included monitoring and managing waste and condition of facilities, displayed on wards. On average the results had improved from 95.2% in September 2017 to 97% in September 2018. On ward 17 we saw that the compliance rate was 100% for September 2018.

We saw that there were noticeboards in use across all areas of the hospital, with information displayed to help patients.
Assessing and responding to patient risk

Systems were in place to assess and monitor patient risk. An effective early warning system was in place to identify deteriorating patients and appropriate action was taken in response to this.

Staff completed and updated risk assessments for each patient. They generally kept clear records and asked for support or escalated concerns when necessary. However, we found that on the AMU, there were inconsistencies in recording information about sepsis. 11 patient notes were examined in this area and we found that in one case there was no information recorded on the sepsis screening tool for a patient that had a raised risk of sepsis, which was blank and not noted in patient notes. Another example showed the sepsis screening tool completed correctly, but the information was not clearly visible within the patient notes.

Anti-microbial stewardship is covered in training sessions across the clinical teams, with emphasis on prompt reviews to enable antibiotic administration to be monitored.

The wards used a modified early warning system (MEWS) to assess patients that might deteriorate. Staff told us that they were changing to the national early warning system (NEWS), but could not tell us if this was the updated NEWS2, that is required to be implemented by March 2019.

During inspection, we reviewed 18 sets of patient notes along with 11 observation charts and sepsis six screening tools. Sepsis is a serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. We saw that scores had been calculated correctly for 10 out of 11 patients and escalated appropriately for patients at risk of sepsis.

Staff had a good knowledge of the sepsis pathway and could demonstrate the triggers and procedures for escalating care for deteriorating patients. We saw in areas like the AMU, that sepsis six screening forms were completed within 15 minutes of the patient being admitted, if they had a higher risk indicated on the MEWS.

There were organisational sepsis and antimicrobial groups in place, to review areas for improvement and development in the management of infection, across all hospital sites.

Staff told us that if they were concerned about a patient’s mental health or wellbeing then any staff member could contact a lead nurse or the Rapid, Assessment, Interface and Discharge team (RAID) team for advice. We were told that RAID team response was good.

We saw enhanced care bundles were available specifically for those patients that were at risk of absconding from wards. This alerted staff to the risks and enabled an appropriate level of observation and security arrangements to be put in place. We saw an example on the AMU where a patient had a history of absconding and staff had been able to manage the care provided appropriately.

Nurse staffing

The service did not always have sufficient numbers of suitably qualified permanent staff with the right qualifications, training and experience to keep people safe from avoidable harm and abuse. However, patients were kept safe by staff being flexible and covering vacancies on wards.

The service used nationally recognised tools for setting and reviewing the establishment for staffing. This was reviewed regularly and the most recent establishment for medical wards at Solihull Hospital showed that there was a 79.9% fill rate. This meant that there was 239.6 whole
time equivalent (WTE) staff required to cover the wards, but there were only 191.5 (WTE) staff in post. This was a decrease in fill rate compared with the data from March 2018 with showed a fill rate of 81.7%.

Staffing issues were managed centrally and managers were responsible for escalating issues for each shift.

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in medicine.

The overall fill rate for qualified nursing staff remained similar at 85.7% in March 2018 and 83.3% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>919.5</td>
<td>966.8</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>528.1</td>
<td>640.4</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>266.0</td>
<td>384.7</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>192.2</td>
<td>235.4</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

On the cardiology ward there was a ‘monitored’ bay for those patients requiring more detailed observation, intervention or support. During this inspection we were told and we saw that a nurse and healthcare assistant were always stationed in this bay.

In AMU we saw that actual staffing met with the planned level and that they had a ward clerk available 24-hours a day to support the management of patients. There were three resuscitation beds, one of which was for paediatric patients, and a side room available to isolate patients if required. All areas within AMU were staffed appropriately to provide support and care to patients.

Between Feb 18 and Oct 18 there were seven incident reports detailing staff shortages and the impact on care. These were reported in AMU, 20B,19, and AMU short stay. In every case there was a requirement for senior staff to step into clinical roles and support with patient care. There were no instances of harm to patients, as a direct result of the shortfall. The shortages were escalated and identified as a risk on the local risk registers. (source DR71)

**Vacancy rates**

Most wards we visited had vacancies for nursing staff. One ward only had 10 nurses in post with a required number calculated as 22. This was a fill rate of 45.5% for that ward. Senior nurses told us that they would rely on bank staff and the goodwill of existing staff to cover any shortfall that occurred. Other wards had less vacancies and were able to ensure that adequate cover was available for all shifts. We were told that recruitment was seen as a priority and that special events to advertise the trust had been arranged to encourage staff to apply for positions. Senior staff said that staffing was their biggest concern and that many recruitment events had been arranged to encourage new staff to join the trust.

From April 2017 to March 2018, the trust reported a vacancy rate of 17.3% for nursing staff in medicine. This was higher than the trust target of 5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.
The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors vacancy rates for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: 9.5%
- Birmingham Heartlands Hospital: 17.7%
- Good Hope Hospital: 26.6%
- Solihull Hospital: 15.2%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 9.7% for qualified nursing staff in medicine. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:
- Queen Elizabeth Hospital: 4.2%
- Birmingham Heartlands Hospital: 14.9%
- Good Hope Hospital: 15.5%
- Solihull Hospital: 16.6%
- Community locations: 13.2%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

Solihull Hospital reported a sickness rate of 4.7% which is equal to the trust wide average, but above the trust target of 3.6%. Senior nurses told us they were not concerned about the level of sickness within their areas, but sometimes there was additional pressure with staff on long term sick or maternity leave.

From April 2017 to March 2018, the trust reported a sickness rate of 4.7% for qualified nursing staff in medicine. This is above the trust targets of 3.6% for Queen Elizabeth Hospital and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

- Queen Elizabeth Hospital: 4.5%
- Birmingham Heartlands Hospital: 5.4%
- Good Hope Hospital: 4.2%
- Solihull Hospital: 4.7%
- Community locations: 2.0%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

Solihull Hospital used bank and agency staff to fill the vacancies that occurred on wards. Senior nurses told us that they used mainly their own staff to cover bank shifts, but there was an increased pressure to use agency staff, due to a drop in the number of staff applying to cover
bank shifts. All staff, including bank and agency, received a trust and local induction. This was reviewed regularly, by the senior nurses and when new staff were used by the hospital. Staff told us that there had been a change in pay agreements for bank working and this had meant a reduction in pay for staff doing bank shifts. This was a trust wide policy and did not exclusively effect Solihull Hospital.

Following the acquisition in April 2018 staff bank arrangements were being reviewed to ensure more opportunities for temporary staffing workers were made available and coordinated across the trust.

**Birmingham Heartlands, Good Hope and Solihull Hospitals**

From April 2017 to March 2018 the trust reported that for qualified and unqualified nursing staff 5.1% of actual hours were filled by agency staff and 21.5% by bank staff across Birmingham Heartlands, Good Hope and Solihull hospitals. The number of unfilled hours, a breakdown by site and staffing type was not provided.

(Source: Nursing bank agency - HGS PIR Return)

From April 2017 to March 2018 the trust reported 13,503 shifts were filled by agency staff, 70,581 by bank staff and 40,565 shifts were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>3,090</td>
<td>53,472</td>
<td>31,820</td>
</tr>
<tr>
<td>Other sites</td>
<td>10,413</td>
<td>17,109</td>
<td>8,745</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

We spoke with seven medical staff during our inspection. They told us they felt well supported to perform their duties and could access senior staff for advice.

Medical and nursing staff on AMU told us of their concerns about the medical cover on night shifts. This was mainly around the requirement to support patients, after 10pm, that were admitted from the minor injuries unit (MIU) due to medical cover in MIU not being available after this time. We were told that patients admitted to AMU overnight, often could have been discharged with minimal intervention, had they been seen by a doctor in MIU.

Although there were doctors trained in general medicine at the correct level to cover the AMU at all times, we were told that there was an increased pressure on the doctors on the night shift to take responsibility for patients on AMU, in addition to the rest of the patients within Solihull Hospital. Staff also told us, there was also an increase of pressure on the doctors coming on duty the next day, to review the extra patient numbers. An AMU consultant was available between 9am and 8pm daily (Monday to Friday) and either am or pm on a weekend and was on call and able to attend the hospital within a 30-minute window.

The most recent data for medical cover for wards at Solihull Hospital showed that there was a 79.2% fill rate. This meant that there was 77.6 whole time equivalent (WTE) staff required to
cover the wards, but there were only 61.4 (WTE) staff in post. This is a decrease in fill rate compared with the data from March 2018 with shows a fill rate of 80.2%.

Junior doctors were well supported and monitored by consultants. Wards would be allocated at least two junior doctors to ensure a consistent approach was maintained. Doctors told us that they felt supported by senior managers and made to feel welcome and part of the team on the wards.

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in medicine.

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in medicine.

The overall fill rate for medical staff dropped from 89.3% in March 2018 to 88.2% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>Actual staff – WTE in month</th>
<th>Planned staff – WTE</th>
<th>Fill Rate</th>
<th>Actual staff – WTE in month</th>
<th>Planned staff – WTE</th>
<th>Fill Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>317.2</td>
<td>321.8</td>
<td>98.6%</td>
<td>339.9</td>
<td>336.0</td>
<td>101.2%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>225.0</td>
<td>251.1</td>
<td>89.6%</td>
<td>217.3</td>
<td>258.3</td>
<td>84.1%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>75.3</td>
<td>110.8</td>
<td>68.0%</td>
<td>71.8</td>
<td>110.8</td>
<td>64.8%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>62.6</td>
<td>78.0</td>
<td>80.2%</td>
<td>61.4</td>
<td>77.6</td>
<td>79.2%</td>
</tr>
</tbody>
</table>

Queen Elizabeth Hospital was over staffed in June 2018 with 3.9 WTE higher than planned.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From April 2017 to March 2018, the trust reported a vacancy rate of 11.8% for medical staff in medicine. This was higher than the trust target of 10% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors vacancy rates for trends and spikes and benchmarks the activity.

The breakdown by site was as follows:

- Queen Elizabeth Hospital: -0.9% (over staffed)
- Birmingham Heartlands Hospital: 10.1%
- Good Hope Hospital: 28.7%
- Solihull Hospital: 16.0%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 4.2% for medical staff in medicine. This is below the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.
The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 2.3%
- Birmingham Heartlands Hospital: 11.1%
- Good Hope Hospital: 12.4%
- Solihull Hospital: 10.7%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 0.8% for medical staff in medicine. This is below the trust targets of 3.6% for Queen Elizabeth Hospital and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and community locations.

A breakdown by site is below:

- Queen Elizabeth Hospital: 0.8%
- Birmingham Heartlands Hospital: 0.6%
- Good Hope Hospital: 0.7%
- Solihull Hospital: 1.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From April 2017 to March 2018 the trust reported that 15,816 shifts were filled by locum medical staff, 7,741 by bank medical staff and that 3,125 were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Locum</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>4,959</td>
<td>2,574</td>
<td>752</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>3,707</td>
<td>2,784</td>
<td>678</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>6,263</td>
<td>1,267</td>
<td>1,559</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>887</td>
<td>1,116</td>
<td>136</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In May 2018, the proportion of consultant staff and junior (foundation year 1-2) reported to be working at the trust was similar to the England average.

Staffing skill mix for the 732-whole time equivalent staff working in medicine at University
Records

Patient records mostly contained the information required to enable staff to provide safe and consistent care.

We saw that wards used paper based notes to form patient records at Solihull Hospital. However, since the acquisition had occurred in April 2018, a review of all systems was taking place with view to updating systems to provide an up to date electronic system that was in place at Queen Elizabeth Hospital. In the recently (May 2018) opened oncology day unit, the patient notes were electronic, but prescriptions were still currently paper based. There was a review taking place to ensure that there was consistency across the trust. Patient notes were scanned into the current electronic system to allow patient records to be accessed by staff across all sites.

We found that patient records were mostly completed appropriately with entries being legible and signed by staff. The entries were specific to each patient and contained relevant information about physical health needs and any other support required for vulnerable patients. Such as, mental health, capacity and dementia assessments.

During inspection, we reviewed 18 sets of patient notes along with 11 observation charts and sepsis screening forms.

We found mostly that records were legible, contained specific details about patient care and were signed and dated and risk assessments were regularly reviewed and updated. We saw that allergy status was recorded in patient notes and that medication reconciliation had been noted along with information about hospital prescribed medications. However, we saw that there were two sepsis assessments that were incomplete, because the information about lactate levels and fluid balance, had been missed.

Patient records were kept in a locked trolley. The wards had several trolleys that were used to transport patient notes around the area, as required and a facility to lock the trolley, ensuring patient information was safe. However, on ward 20A, two out of the three trolleys had a broken lock and so were returned to the nurse’s station after use, for better monitoring. We were told that the locks had been reported and that they would be repaired the next day. We did not confirm whether this had been done.
Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

However, some medicines requiring refrigerated storage, were not always stored in a room with the correct temperature. On all of the wards we visited, the temperature checks showed that the room temperature was higher than the maximum required. In some cases, fans had been put in place to help keep areas cooler. Ward 17 regularly had recorded temperature above 25 degrees and staff told us that it was difficult to get the temperature of the room to below 25 degrees. They told us that the door could be opened when the room was occupied, to enable cooler air to circulate.

In most cases we saw that fridge temperatures were recorded correctly and were within the required temperature ranges. We did see on two wards where temperatures had not been recorded for some days.

Controlled drugs (CDs) were stored correctly in a locked cupboard and in a room with a security number code to gain entry. The keys to the CD cupboard were held by the senior nurse in charge or the ward manager. Staff would be required to collect and return the keys to the nurse in charge. We saw notices to staff, in staff rooms and medicine storage areas, to remind staff to return the keys. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs.

Wards had pharmacy technicians available to them and a pharmacist would visit wards daily to support in medicines management. We were told that there had been an initiative where pharmacists would be proactive in the approach to managing patients medicine on discharge. This involved there being a focus on ensuring medication was discussed well in advance of discharge to assist in reducing delays. Ward staff told us that there were few occasions when the lack of medication delayed discharges. The relationship between ward staff and pharmacy staff was good.

We saw in areas such as AMU, that nurses were trained and competent in administering antibiotics. There was a protocol in place for staff to follow and support available from the pharmacists.

There were permanent oncology pharmacists on site at the oncology day unit.

We saw that medical gases were stored correctly in all the areas we visited.

The hospital information and electronic prescribing system, is being reviewed to allow assessment of antimicrobial prescribing, across the hospital sites.

Incidents

The service generally managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. However, we found two examples where learning from an incident was missed or could have been improved.

The incident reporting culture, overall, was good. However, we did find that one member of staff had told us about an incident where a specific IV solution had been prescribed for a patient and there had not been any available at Solihull Hospital. The incident was managed by obtaining the required IV solution from another hospital within the trust and there was no harm caused to the patient. We could not find any record of this incident on the reporting system, despite the member of staff saying it had been reported.
A member of staff told us that there had been an incident where a patient had absconded from Heartlands Hospital and then admitted to Solihull Hospital. There were difficulties with the patient and an incident report was submitted, however, communication had been poor in this case and staff had requested feedback from the incident and not received any. This was a missed opportunity for learning.

The Hospital used an electronic incident management system and staff could demonstrate it during inspection. Staff told us that they had reported incidents and they were encouraged to do so. Following the acquisition, there had been a review of the incident reporting system to ensure that a system could be developed to provide consistency across all hospital sites within the newly formed trust. This review had not been completed at the time of inspection.

Incident trends were reported to the divisional clinical quality group and to the board through the clinical quality monitoring report.

When things went wrong, staff apologised and gave patients honest information and suitable support. Staff understood the duty of candour process and senior staff described when it had been used to follow up incidents.

The duty of candour is a regulatory duty that relates to openness and transparency and requires Providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’.

Following the acquisition in April 2018, the duty of candour policy for Solihull Hospital was being reviewed, to ensure consistency across the trust.

We saw that there had been learning from incidents with the introduction of a “do not disturb” armband, that was worn by staff to indicate that they were not able to leave the bay. This helped prevent a nurse being asked to complete a task away from the bay where there might be patients who were at risk of falling.

Another example followed an incident where a diabetic patient needed specific fluids and there was not enough information available to staff on the cardiology ward. A specialist consultant arranged for information to be available to staff on the ward, to escalate appropriately for different types of concern. This was shared across all hospital sites within the trust.

We saw an example of a recent incident on the oncology day unit where blood was infused over a shorter time period than prescribed. There was no patient harm and as a result the senior nurse changed the labelling to be clearer along with informing all staff of the outcome. Feedback from incidents was given at monthly team meetings and all staff were emailed with the details. There were daily huddles where staff could discuss specific patient concerns.

Morbidity and mortality reviews were taking place monthly and we saw minutes from the reviews along with the divisional governance meetings, could be escalated to the executive team. We were told that the review of all meetings would ensure consistency across the whole trust, post acquisition.

All serious incidents and never events were investigated and communicated through local and trust wide governance meetings, which allowed improvement and learning to be identified and discussed with staff.

Never Events
There were no recorded never events in medical care at Solihull Hospital in the 12 months leading up to inspection.

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to
cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust reported one incident classified as a never event for medicine.

This occurred at Birmingham Heartlands Hospital in March 2018 and related to a medication incident where a patient requiring oxygen was unintentionally connected to an air flowmeter.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 78 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2017 to July 2018.

The breakdown by type of incident reported were:
- Slips/trips/falls with 36 (45.6% of total incidents)
- HCAI/Infection control incident with 32 (41.0% of total incidents)
- Pressure ulcer with six (7.7% of total incidents)
- Treatment delay with two (2.6% of total incidents)
- Surgical/invasive procedure incident with one (1.3% of total incidents)
- Medication incident with one (1.3% of total incidents)

Site specific information can be found below:
- Queen Elizabeth Hospital (August 2017 to July 2018): 60 incidents
- Good Hope Hospital (April to July 2018): 11 incidents
- Birmingham Heartlands Hospital (April to July 2018): five incidents
- Solihull Hospital (April to July 2018): two incidents

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 63 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2017 to March 2018.

The breakdown by type of incident reported were:
- Slips/trips/falls with 25 (39.7% of total incidents)
- Pressure ulcer with 21 (33.3% of total incidents)
- HCAI/Infection control incident with nine (14.3%)
- VTE with two (3.2% of total incidents)
- Sub-optimal care of the deteriorating patient with two (3.2% of total incidents)
- Medication incident with two (3.2% of total incidents)
- Diagnostic incident including delay with one (1.6% of total incidents)
- Confidential information leak/information governance breach with one (1.6% of total incidents)

Site specific information can be found below:
- Good Hope Hospital: 30 incidents
- Birmingham Heartlands Hospital: 26 incidents
- Solihull Hospital: seven incidents

(Source: Strategic Executive Information System (STEIS))

**Safety thermometer**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the
The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.

Nursing Dashboards were populated each month for the whole of division 4, which included Solihull hospital. This information fed into the ‘ward to board’ report and eventually into the nursing and midwifery board report.

The dashboard indicated performance against several measures and compared to set standards that staff could use to improve quality of care. These included, harm free care, patient falls, tissue viability, Venus thromboembolism (VTE) and medication prescribing, such as antibiotics.

Data collection took place one day each month – a suggested date for data collection was given but wards could change this. Data was to be submitted within 10 days of suggested data collection date.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported 117 new pressure ulcers, 45 falls with harm and two new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Heart of England NHS Foundation Trust**

<table>
<thead>
<tr>
<th>1</th>
<th>Total Pressure ulcers (117)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Total Falls (45)</td>
</tr>
<tr>
<td>3</td>
<td>Total CUTIs (two)</td>
</tr>
</tbody>
</table>

1 Pressure ulcers levels 2, 3 and 4
Is the service effective?

Evidence-based care and treatment

The service had systems in place to ensure that care and treatment was based on national guidance and evidence of its effectiveness.

Patient care was delivered in line with trust policies and pathways based on national guidance including, National Institute for Health and Care Excellence (NICE) and Royal College of Physicians guidance. Staff could access this information through the local intranet or the internet. On some areas, we saw paper copies of some guidance in a folder on the nurse’s station, to enable staff to access information without logging into a computer. A nurse had been identified to review the information and ensure that paper copies were the most up to date versions available to staff.

There was an older person’s assessment and liaison (OPAL) team that had been set up to provide support to patients and information to staff. There was a consultant, occupational therapist and physiotherapist in the team that provided specialist support when dealing with elderly or frail patients. We saw assessments in patient records that had involved the OPAL team.

Patients on all wards, were reviewed during a consultant led ward round at least once every 24-hours, including during the weekends. The AMU had a consultant available from 9 AM to 8 PM and patients were reviewed twice daily by a consultant.

Medical services participated in national clinical audits such as, the Sentinel Stroke National Audit programme (SSNAP), which are noted further down in the evidence appendix.

The endoscopy unit was accredited by the Joint Advisory Group (JAG) for GI Endoscopy in May 2018. Treatment and procedures had been assessed to be in line with international best practice standards. JAG accreditation is an indicator of high quality performance in line with international standards.

We saw on the oncology day unit that policies, such as the extravasation policy, were up to date and based on NICE guidelines. Extravasation is the leakage of intravenously (IV) infused potentially damaging medications into the extravascular tissue around the site of infusion.

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 preferences.

We found that most wards encouraged family members to get involved with assisting patients at meal times. Patients were monitored for their intake of fluids and food and we saw that patient information was noted on food and hydration charts within patient records. Patients had their nutritional needs assessed within 24 hours of admission, using the malnutrition universal screening tool (MUST). The MUST calculates the overall risk of malnutrition and provides staff with information on escalating a patient’s nutritional needs. We randomly checked eight charts and
found them to be completed correctly. There were specialist nurses available in the speech and language team (SALT) to support patients that were having difficulty with swallowing, which affected their nutrition.

There were specialist dieticians available to support patients with their dietary needs. Staff would liaise or refer to the dieticians in cases where patients required a specialist diet or if there was difficulty in eating. For example, patients that were using nasogastric (NG) tubes.

The 2018 PLACE (patient led assessments of the care environment) audit showed Solihull Hospital had achieved 92.2% for the food and hydration assessment. This was better than the England average (90.2%).

Patients told us that they were offered drinks regularly and that the staff would give them fresh water. Requests could be made for extra food and drink and patient feedback was that were never left without access to a drink. Special diets, based on belief, allergy status or personal preference could be catered for by the hospital.

**Pain relief**

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

If a patient was in severe pain on admission, a referral to a pain specialist would be considered. All patients we spoke with told us they received pain medication if required.

A numerical pain assessment tool was used on all wards and recorded on the observation chart. Pain medication was made available immediately that pain had been assessed and patients were assessed regularly to monitor any changes. We saw patient notes with documented pain assessments completed appropriately. However, staff could not tell us how they would assess pain if a patient was unable to communicate verbally.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Following the acquisition in April 2018, audit processes were reviewed to ensure a consistent approach was maintained and to share best practice.

We saw examples of audits that had been developed at Queen Elizabeth Hospital, that were to be shared across all sites within the newly formed trust. We were told that the clinical audit programme was being developed to provide consistency in the quality of audits across the trust. Although audits across all sites had not yet been coordinated, we saw examples of audits that were planned to be adapted and introduced to Solihull Hospital, as part of the audit plan. For example, pain in children audit and managing antibiotics audit.

Waiting time audits had been completed weekly on the oncology day unit. The maximum time waited was 30 minutes and staff were aiming to keep the times below this. The unit also completed other metrics audits such as blood observations and IPC, which we saw were showing 100% compliance.

We saw that length of stay could vary from 6 hours to 60 hours on the AMU. On average a patient would stay between 6 to 8 hours, but if a patient needed a cardiology bed the wait could increase to 14 hours. Patients with complex mental health needs could wait for 60 hours for an appropriate bed to be found.
Relative risk of readmission

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Solihull Hospital – elective admissions

From May 2017 to April 2018, patients at Solihull Hospital had a higher than expected risk of readmission for elective medical admissions compared to the England average.

- Patients in gastroenterology and cardiology had higher than expected risks of readmission for elective admissions.

- Patients in clinical oncology had a lower than expected risk of readmission for elective admissions.

Elective Admissions - Solihull Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Solihull Hospital - non-elective admissions

From May 2017 to April 2018, patients at Solihull Hospital had a lower than expected risk of readmission for non-elective medical admissions compared to the England average.

Patients in general medicine, respiratory medicine and geriatric medicine had lower than expected risks of readmission for non-elective admissions.

Non-Elective Admissions - Solihull Hospital
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Sentinel Stroke National Audit Programme (SSNAP)

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Birmingham Heartlands Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in latest audit, August to November 2017. This was a drop from the previous A grade, which the trust has achieved in the previous four quarters.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>C↓</td>
<td>B↑</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
<tr>
<td>level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Similarly, the trust scored an overall patient centred performance grade of B, which was a drop from the previous three quarters which had achieved an A. The only domain to drop in the most recent audit was specialist assessments, however the stroke unit and speech and language therapy domains have both been consistent in scoring a C and are the lowest rated domains.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>A</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A↑</td>
<td>B↓</td>
<td>A↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>
The team centred performance was also awarded a B in the most recent audit, dropping from an A. Speech and language therapy was awarded a C grade, which is lower than the previous five audits. The stroke unit has achieved a C grade in five out of the last six audits.

<table>
<thead>
<tr>
<th>Team centred performance</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C↓</td>
<td>C</td>
<td>B↑</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B↓</td>
<td>B</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>B↓</td>
<td>B</td>
<td>C↓</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C</td>
<td>B↑</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>D</td>
<td>C↑</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Team-centred total key indicator level</td>
<td>B↓</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London, SSNAP audit)

Lung Cancer Audit

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 64.7%, which did not meet the audit minimum standard of 90%. The 2016 figure was 61.4%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 17.2%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 62.2%. This is within the expected range. The 2016 figure was not significantly different to
The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 72.5%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2016 was 34.0%. This is within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

The 2017 National Audit of Inpatient Falls was carried out prior to the acquisition by acquisition of University Hospital Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust and has therefore not been included in this report.

(Source: Royal College of Physicians)

Competent staff

Systems were in place to ensure staff were competent for their roles. Managers appraised staff’s work performance and completed competency assessments as required.

We spoke to new members of staff that told us they were happy to be working at Solihull Hospital. One had actively sought employment at the hospital based on its reputation.

New staff had received an induction that was applicable to the hospital and to the wards on which they were working. We saw that a nurse had been given two named mentors and that they were given time where they could develop and learn as an extra member of staff, to enable them to shadow qualified nurses.

Training needs were identified and staff of all grades told us that they felt supported and could access training to support their roles. We saw that staff had received training, in addition to the mandatory training, such as paediatric life support for all staff on AMU. Supervision and guidance was available to staff on a one to one basis. Staff told us they had regular meetings with managers and could ask for extra support at any time.

Nurses on the oncology ward spent 2 weeks with a clinical educator as part of the induction programme, to ensure that supervision was given for the administration of chemotherapy medication. A nurse could not give chemotherapy medication for the first month after starting on the unit, to allow for adequate supervision and training.

We saw good examples where staff had discussed individual competencies within a team, to enable specialist skills to be used more effectively. For example, ward 17 had developed a more integrated approach to enable nurses to understand and share each other’s skills to support patient care. This also gave an opportunity to learn skills from each other.

We saw many volunteer staff working on the medical wards and in other areas across the hospital site. Volunteers were used to support patients and families when in the hospital. We spoke with two volunteers who said that they mainly helped people get to the right areas or wards by giving directions or walking with them to the wards. Volunteers would help with a variety of tasks such as locating patient information, offering refreshments and generally supporting patients and staff.
Volunteer staff completed aspects of mandatory training which included infection prevention and control, safeguarding, information governance, fire safety, dementia awareness, health and safety, food hygiene, and manual handling.

**Appraisal rates**

We found that in most cases staff had received an appraisal within the last 12 months. Those that had not, had a time and date set to complete the appraisal by the end of the year. We saw examples on every ward we visited where there was published information about appraisal, mandatory training and supervision for nursing staff. For example, on ward 19 we saw that 15 out of 17 staff had received an appraisal and the two that had not, were due to sickness. Dates had been arranged for the two to be completed in October 2018.

**Solihull Hospital**

From April 2017 to March 2018, 90.8% of staff within medicine at Solihull Hospital received an appraisal compared to a target of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental staff</td>
<td>21</td>
<td>21</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>20</td>
<td>21</td>
<td>95.2%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>170</td>
<td>187</td>
<td>90.9%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>58</td>
<td>64</td>
<td>90.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>17</td>
<td>22</td>
<td>77.3%</td>
</tr>
</tbody>
</table>

Qualified allied health professionals were the only staff group that failed to meet the target completion rate. However, we saw that for some groups there were plans in place to increase the amount of training available, to improve the compliance.

**Multidisciplinary working**

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

Multi-Disciplinary Team (MDT) meetings were specifically arranged to ensure experts were involved, to agree the most appropriate treatment for the patient. We attended three board rounds on different wards, during inspection and found that they were consultant led and attended by a multi-disciplinary team that included occupational therapists, doctors, nurses, physiotherapists and senior nursing staff. There was involvement from physiotherapists, occupational therapists and dietitians on inpatient wards and specialist leads or champions were available for advice.

A new electronic booking and referral system had been introduced to remove the need for paper referrals to be processed. The system provided an easier and more efficient way for GP’s, staff and patients to make referrals to Solihull Hospital. This initiative had been developed in collaboration with NHS England, NHS digital, NHS improvement and supported by the commissioners of the service.

We found that on ward 8, every member of staff knew each other and used first names to create a calm and friendly atmosphere. Staff knew every patient and could discuss their needs without
consulting patient records. Patients were only moved for clinical needs and so stability had been created on the ward.

Staff told us that everyone that worked at Solihull Hospital was part of a team and that support was always available across specialities, to improve patient care. We saw examples where staff with specialist knowledge had been included in patient care and contributed to decisions about individual care plans. One patient, that had several underlying conditions, was treated for a stroke but also had specialist input from heart and renal specialists. However, staff described difficulty in transferring patients from AMU to specialist services. For example, we were told that on occasions patients that required surgery at another hospital, heartlands or Queen Elizabeth, would be delayed transfer whilst further tests were completed.

We saw good examples where other organisations, such as Macmillan nurses and charities, worked hand in hand with the staff on the oncology day unit, to provide the best care possible for patients. Referrals and signposting to other services was smooth and simplified for the patient.

**Seven-day services**

Before April 2018, the former trust, Heart of England had participated in the seven-day clinical service survey. Solihull Hospital had results showing they were performing above the national standards for being seen by a consultant within 14 hours of admission, access to diagnostic tests, consultant directed interventions and daily ongoing consultant reviews. This initiative was used to set action plans and learning points that were still in place during the inspection.

There was a 24-hour service available at the trust, for patients who required thrombolysis following a diagnosis of a stroke, patients at Solihull Hospital could access this and be transferred to another site, if required. This service was provided seven days a week and could be accessed at Queen Elizabeth and Heartlands Hospitals.

Consultant cover on a weekend was often met by staff covering the duty voluntarily. We saw that a consultant had worked on ward 8 to follow up with patients or their families, but often they would also cover for all medical wards at Solihull Hospital for the whole day. A consultant was available on the weekend during the day and could be contacted on call at night.

Consultant cover for the AMU was based on a rota and a consultant would visit the area regularly throughout the day. They were available at any other time, including through the night, by a telephone call for advice. The consultant was also available to visit AMU at any time, upon request.

**Health promotion**

Patients were supported to live healthier lives and manage their own care and wellbeing needs where appropriate.

We saw health promotion information on all the wards we visited. The information was mostly displayed on noticeboards that had been dedicated to a subject. For example, there was a comprehensive display on the elderly care ward about oral health and the importance of keeping mouth and dentures clean. The information was aimed at both staff and patients.

Most wards we visited had information in leaflet form about dementia awareness and support information for patients with mental health concerns.

Staff told us that patients would be given specific advice depending or relating to specific conditions. For example, oral health information was available on the elderly care wards and diabetes information was located on every ward that we visited.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental illness and those who lacked the capacity to make decisions about their care.

Following UHBs acquisition of HEFT, work was ongoing to align systems and processes to monitor and ensure a consistent approach was developed across all sites, to support the most vulnerable patients. The trust is in the process of reviewing staffing in the safeguarding team with view to recruiting mental health act (MHA) administrators to support compliance with the MHA and ensure the rights of detained patients are protected.

We saw a comprehensive guide to supporting people living with dementia, had been developed by the trust. We spoke with dementia leads and staff on wards who could clearly describe the guidelines and applied it to patients in their care. Leaflets were available on every ward to inform staff and patients about dementia care. However, four members of staff, in different areas, told us they had not yet received formal dementia awareness training.

On the stroke ward we saw that regular reviews took place to discuss the mood of each patient to assess mental well-being and post stroke depression. We also saw that an agency mental health nurse had been employed to specifically support and monitor patients that were challenging or had particular mental health needs.

We saw patients that had Deprivation of Liberty Safeguards (DoLS) in place and noted that in two cases that the information had not been updated in the patient record. Referrals were made electronically and then printed out to add into patient records, but there was no signature on the copy. We saw that referrals were appropriate and after seven days, the local authority reviewed and authorised DoLS. Mental capacity assessments were completed and we observed assessments that had been completed to provide emergency treatment, in the best interest of the patient. However, we were not assured that all staff were consistent in updating all the patient records to reflect the most up to date information.

There were link nurses in post on most of the wards we visited. On the oncology day unit, we spoke to a link nurse that mainly dealt with DoLS issues associated with the type of treatments given on the ward. Patients with dementia would be treated at Heartlands Hospital in preference to the oncology day unit at Solihull Hospital. This was to maintain higher levels of safety for patients with specialist medical cover being available.

Patients with learning difficulties were assessed on a case by case basis, with consultant input into the care arrangements. We saw an example where a patient was assessed under the mental capacity act and supported by a learning disabilities lead nurse. Once treatment was underway the patient was seen by a community nurse and introduced to the service as an introduction to possibly being treated at home.

We were told that there was an older person assessment and liaison team (OPAL) that were available to support patients arriving into wards such as the AMU, to offer advice for staff and patients about the care required.

**Mental Capacity Act and Deprivation of Liberty training completion**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Currently the trust has only been able to provide data for the Queen Elizabeth Hospital site, information for the other sites has been requested and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to
complete this section.

The trust combines safeguarding level 2, mental capacity and deprivation of liberty (DOLs) training.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Solihull Hospital

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for qualified nursing staff in medicine at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>133</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met for this training module.

A breakdown of compliance for mental capacity and DoLS training courses from April 2017 to March 2018 for medical staff in medicine at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLS and mental capacity</td>
<td>50</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was not met for this training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. We observed patients receiving compassionate care. Without exception, feedback from patients was positive. Patients told us that staff treated them well and with kindness. Patients spoke positively about the care they received and told us that the staff were “wonderful” and “couldn’t do enough for me”.

Staff ensured they were familiar with each patient’s family, social arrangements and their support network. We saw examples when nurses and occupational therapists talked to patients about plans that included family members and individual circumstances, to support their recovery.

We saw staff assisting with personal hygiene and helping patients to change their clothing. The care taken to ensure dignity and kindness was maintained was exceptional. We saw staff
monitoring patients whilst they ate and if any food was spilled, clothing or bed linen was changed immediately. We were told that patients on ward 8 were monitored with particular care because food spillage was common and staff did not want patients to be sitting in any kind of mess.

On one occasion, we saw a nurse knock on the door to a side room and ask if they could enter. They talked to the patient throughout the consultation and pulled curtains around to ensure privacy was maintained at all times. The conversation was personal to the patient and the nurse asked about their family and visiting arrangements. Time was taken to discuss the things that mattered to the patient and although the nurse was performing a task, it was not rushed or completed in silence.

**Friends and Family test performance**

We have included data from the pre-acquisition period for Queen Elizabeth Hospital in this analysis. Because it related to the same legal entity, University Hospitals Birmingham NHS Foundation Trust, we have used this to form part of our judgement. Data for Heart of England NHS Foundation Trust has only been included post-acquisition.

**Solihull Hospital**

We saw friends and family test (FFT) cards available outside every ward and there was a specific box for people to post their replies. FFT cards were also given to all patients on discharge from the wards. The information was collated centrally for the hospital and information then displayed on the FFT noticeboards, on the wards.

On ward 8 we saw that the FFT response rate was 53% and that 97% would recommend the service provided. On the AMU we saw that the response rate was 30% with a recommendation of 91%. However, there was no FFT information or post box on the oncology day unit. Staff told us that they were waiting for it to be installed.

The Friends and Family Test response rate for medicine at the Solihull Hospital was 34.3% from April to June 2018.

No wards had more than 100 responses, so we are unable to provide a breakdown. All medical wards had a recommended rate of over 95% for April to June 2018.

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

We observed interactions between a consultant and a patient living with dementia. The consultant was kind, understanding and supportive, taking time to communicate and inform the patient in a way that exceeded expectations.

Staff on the oncology ward and day unit, had introduced resources to support children affected by cancer. They had developed “cloud kits” in three age ranges, 3-5 years, 6-10 years and 11-16 years old, to give information to children that were affected by cancer. They were designed to give honest and sensitive answers to difficult questions and provide appropriate advice.

The oncology ward provided a 24-hour helpline for anyone to access, especially those undergoing chemotherapy.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care.
Without exception, patient and family members we spoke with told us they were informed of all aspects of their treatment. There were examples where a consultant had gone the extra mile to support patients and keep family members informed. On one occasion there had been a Skype call set up at a weekend to enable relatives living in Australia to be kept informed about the care of a loved one.

There were examples where staff had gone over and above what was expected to care for patients. Examples included, where a doctor had attended ward 8 on their day off, to ensure a patient was informed of changes to a discharge plan.

Staff told us that the patients holistic care was the key to their successful outcome.

We saw other staff explaining the plans for a patient discharge, to a family member. The nurse in charge was patient and understanding of the concerns and explained the plans clearly and in a way that could be easily understood.

Patients told us that the staff involved them in all discussions about their care. We saw that staff would arrange visits with family members to enable a full explanation to be given. These arrangements had been made at times most suitable to the patient and family members.

A family member told us that the care had been very good on ward 20A and that they had been included in discussions about care and discharge planning. They said that the consultant and other doctors had explained everything to them in a way that made them understand the medical problems.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

*The trust planned and provided services in a way that met the needs of local people.*

A new oncology day ward had been created at Solihull Hospital to improve the quality of care given to patients from across the trust. The unit had been developed in consultation with patients and staff to ensure that the location and facility would benefit patients. Patients from a variety of locations, accessed the ward to compliment or progress treatment that had started at any of the hospitals within the trust.

The unit was opened in May 2018 and 50% of the staff from the original unit at Heartlands Hospital, moved to work at the new unit.

There was an acute stroke unit (ASU) at Solihull hospital, with a hyper acute stroke unit (HASU) located at Heartlands and Queen Elizabeth (QE) Hospitals. This meant that stroke services were divided across all four sites across the trust. As a result, thrombolysis had been limited to two sites instead of being available at all four sites. Thrombectomy services were being developed on the QE site to give patients more choice of location.

The acute medical unit (AMU) received patients from the minor injuries unit, oncology day unit, GP’s and ambulance, if a patient is acutely unwell. There was a waiting area and a step down area, with five recliner chairs for patients that were suitable to sit. We were told that on occasions patient moves to specialist services were delayed, due to availability of beds. Patients awaiting surgery on another site, could be delayed whilst further scans or tests were carried out at Solihull Hospital.

We saw an example of the service meeting the needs of local people by introducing specialist staff to tackle the increase in numbers of patients requiring intervention for congenital hip problems. The increase had been identified through screening and a business plan developed. The successful change made had seen a decrease in the number of people and the times they
were waiting.

The signs to wards were clear and accurately directed people to the correct levels for the wards. Access to the upper level was provided by several staircases and lifts were available for people with difficulty in mobilising. However, we saw that one ward was still signposted as community assessment unit (CAU), but was in fact an elderly care ward. We were told that this ward had not been the CAU for 18 months.

**Average length of stay**

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

**Queen Elizabeth Hospital**

From March 2017 to February 2018 the average length of stay for medical elective patients at Queen Elizabeth Hospital was 5.1 days, which was shorter than the England average of 6.0 days.

Average lengths of stay for elective specialties:

- Average lengths of stay for elective patients in medical oncology and clinical oncology were shorter than the England averages
- Average length of stay for elective patients in cardiology was similar to the England average

**Elective Average Length of Stay - Queen Elizabeth Hospital**

![Elective Average Length of Stay - Queen Elizabeth Hospital](image)

*Note: Top three specialties for specific site based on count of activity.*

Over the same period, for medical non-elective patients, the average length of stay was 6.2 days, which was similar to the England average of 6.4 days.

Average lengths of stay for non-elective specialties:

- Average length of stay for non-elective patients in nephrology and medical oncology were longer than the England average
- Average length of stay for non-elective patients in general medicine was similar to the England average
Non-Elective Average Length of Stay - Queen Elizabeth Hospital

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Solihull Hospital

From March 2017 to February 2018 the average length of stay for medical elective patients at Solihull Hospital was 2.8 days, which was shorter than the England average of 6.0 days.

Average lengths of stay for elective specialties:
- Average lengths of stay for elective patients in gastroenterology was shorter than the England average
- Average length of stay for elective patients in cardiology and pain management were similar to the England average

Elective Average Length of Stay - Solihull Hospital

Note: Top three specialties for specific site based on count of activity.
Over the same period, for medical non-elective patients, the average length of stay was 3.6 days, which was shorter than the England average of 6.4 days.

Average lengths of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine, respiratory medicine and geriatric medicine were shorter than the England averages

### Non-Elective Average Length of Stay - Solihull Hospital

![Bar Chart]

Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

### Meeting people’s individual needs

The service took account of patients’ individual needs.

We found that on some wards, such as the care for the elderly ward, there were therapy support workers who were employed to assist patients to “eat, drink and move”. This meant that patients were encouraged to be mobile and attempt daily tasks, to support recovery. We saw staff assisting patients in doing their hair and painting finger nails whilst encouraging the patients to communicate with each other or staff.

Patient notes and the electronic information board, used a symbol to highlight if a patient was living with dementia or had extra care needs. The butterfly symbol is used to denote a vulnerable elderly patient or a person living with dementia. We saw examples where information had been added to patient notes, to highlight any concerns or if they were vulnerable.

There was a multi-faith room available for patients to attend services or to use individually at any time of the day or night. The area was visibly clean and tidy and could facilitate the needs of any group of people. We saw services advertised and they included several different religious beliefs.

Staff we spoke to told us that they had received basic dementia care training and they knew how to signpost patients to more specialised care. There was dementia leads within the trust and staff could access specialist knowledge when required.

Patients with visual impairments could access information that had been printed in larger or bolder text to aid them. There was a hearing loop available in some areas, for patients that had hearing difficulties or wore a hearing aid.
We witnessed staff asking people if they needed directions and there were many volunteers available to assist.

There were noticeboards on every ward to display information to staff and patients. Some were specific to a subject, for example, we saw a diabetes noticeboard with information for patients. There was information about good oral health located on the elderly care wards, which gave useful information and instructions for maintaining good mouth hygiene.

We saw on the oncology day unit that patients could access charities or other sector organisations to assist with their care. Macmillan cancer services were located in the unit, along with specialist dieticians and life coaches.

A learning disability webpage was set up on trust intranet staff to access. There were links to specific documents such as a learning disability toolkit and “my hospital book” along with other information and leaflets.

Lead nurses were available to support staff when dealing with a patient with learning difficulties. They would assist in assessment and care planning for any patient that was identified as vulnerable. Staff told us that they would contact a lead nurse for advice when a patient was presenting as vulnerable.

Patients with conditions like dementia, diabetes and epilepsy were supported by clinical nurse specialists, that were available across the trust. We saw in some areas, that a dementia trolley was available to provide equipment and other useful items to help care for patients living with dementia. For example, we saw that there was a trolley on AMU that had items such as colouring books and games, available for patients, carers and family members.

We saw “about me” forms in place for patients that were vulnerable or had specific needs. These documents made information available to staff, in order for them to provide specific support or care to a patient, taking into consideration the likes and dislikes of the patient.

We saw a patient on ward 8 that had been identified as having some learning difficulties. There were appropriate referrals to RAID completed, along with evidence of safeguarding concerns and appropriate referral in place. All were noted in the patient record, however, there was no “this is me” documentation in place at the time. Staff told us that the patient was lower risk due to being assessed as low-level learning difficulty and a patient passport was not deemed necessary.

The endoscopy ward had contingencies in place in case of an increase of patients of one or another gender. There were rooms and areas that could be reconfigured or isolated to ensure there were no mixed sex breaches. This involved positive multi-disciplinary working with the adjoining ward.

**Access and flow**

**People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

We saw that bed moves were kept to a minimum and that any moves were based on clinical needs of the patient. Discharges were discussed well in advance to enable a smoother process and to ensure support is in place.

Bed managers understood the need to manage specialist admissions for the patient to receive the right care. Patients that had suffered a stroke were admitted to the correct ward and prioritised when spaces were not available. This would include bed or site managers liaising with each other on different sites within the trust.
Referral to treatment (percentage within 18 weeks) - admitted performance

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

From August 2017 to July 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.

Referral to treatment (percentage within 18 weeks) – by specialty

University Hospitals Birmingham NHS Foundation Trust
We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>97.1%</td>
</tr>
<tr>
<td>General medicine</td>
<td>99.6%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>98.8%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.4%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>92.9%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>92.4%</td>
<td>91.0%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>93.4%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>78.0%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Four specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>100.0%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>99.5%</td>
<td>92.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.9%</td>
<td>82.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>95.0%</td>
<td>93.9%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within medicine for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>94.1%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>69.6%</td>
<td>81.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

**Patient moving wards per admission**

From April 2017 to March 2018 the trust did not report any patient moves for non-clinical reasons
Patient moving wards at night

The trust reported the ward moves at night data separately for all sites.

Solihull Hospital

From July 2017 to June 2018, there were 211 patient moving wards at night within medicine.

The wards with the highest number of ward moves at night were:

- Ward 19 – Respiratory with 57 moves (27.0%)
- Ward 17 – Cardiology with 54 moves (25.6%)
- Ward 20B – General medicine with 35 moves (16.6%)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The trust had an up-to-date complaints policy, which was being reviewed along with a variety of policies since the acquisition in April 2018. The policy was available for staff to access on the staff intranet and we saw a paper copy available on ward 8.

We saw notices and other information explaining the process for a complaint to be made and information on who to contact.

The policy and procedure provided guidance and standards for the handling of complaints. We were told that the divisional heads of nursing reviewed all complaints to determine who would lead an investigation into the complaint. A dedicated complaints officer managed the complaints for each division and they managed reports, draft responses and arranged meetings, if appropriate. Senior managers told us that the head of patient services had meetings with divisional head nurses to discuss complaints and themes, trends and formulates actions. We saw an example where a complaint about the car park access to the oncology day unit, instigated a better way of attending for appointments. Due to a barrier there was reduced access to the day unit and often patients would have to be dropped off and walk a distance to their appointment. Changes were made for the barrier to be lifted to allow patients to be dropped outside the unit or park closer to the service. This applied specifically to the patients using the day unit and helped flow and access to the car parking facility.

Another example was when a complaint was received about the comfort of chairs in the waiting room at the oncology day unit. The trust replaced the seating for more appropriate comfortable chairs, despite the facility being almost new.

Summary of complaints

Trust level

From April 2017 to March 2018 there were 201 complaints about medical care across the trust. The trust took an average of 42 working days to investigate and close complaints, this is not in
line with their complaints policy, which states complaints should be closed within 30 working days.

Of the 25 complaints still open at the time of reporting all had been open longer than the trust target of 30 working days, the longest being open for 231 working days.

A breakdown by site is below:

- Queen Elizabeth Hospital: There were 104 complaints, the main themes were patient care with 30 complaints (28.8%), clinical treatment with 20 complaints (19.2%), communications with 18 complaints (17.3%) and admissions, discharges and transfers with 13 complaints (12.5%)

- Birmingham Heartlands Hospital: There were 48 complaints, the main themes were all aspects of clinical treatment with 28 complaints (58.3%) and admissions, discharge and transfer arrangements with 11 complaints (22.9%)

- Good Hope Hospital: There were 35 complaints, the main themes were all aspects of clinical treatment with 16 complaints (45.7%), communication/information to patients with five complaints (14.3% and admissions, discharge and transfer arrangements with four complaints (11.4%)

- Solihull Hospital: There were 14 complaints, the main theme was all aspects of clinical treatment with eight complaints (57.1%)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 727 compliments within medicine.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>689</td>
<td>94.8%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>20</td>
<td>2.8%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>9</td>
<td>1.2%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>7</td>
<td>1.0%</td>
</tr>
<tr>
<td>Birmingham Chest Clinic</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Morris House</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>727</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

Managers at all levels had the right skills and abilities to run this service providing high-quality sustainable care.

A division 4 triumvirate team, made up of a divisional head of nursing, a divisional medical director and a divisional head of service managed medicine at Solihull. We spoke with all three leads and they could inform us of the previous performance and future plans, post acquisition. The team had
been in place for two and a half years and were part of the team that made improvements following the previous inspection in 2016.

They demonstrated good knowledge of performance at the wards at Solihull, Heartlands and Good Hope Hospitals and were a team that had developed over many years and were well appraised of the requirements in their areas, going forward.

Due to the recent acquisition (April 2018) they were reviewing all aspects of medicine at Solihull Hospital, in line with all of the other sites. They told us of a plan that was being developed to ensure consistency across the whole trust.

The divisional leads were mostly visible and supportive of changes that the acquisition would bring. Staff we spoke to confirmed that the senior managers would visit areas and could be approached for support and advice. Staff told us that information, in general, was available to them. However, staff said some wards appeared to have a higher priority and received more attention from senior team. They gave the oncology day unit as an example where the attention from the senior team had been focussed.

We found examples where local leaders had gone above and beyond what was expected of them, to support patients and staff. One example was where a consultant had facilitated a skype meeting with relatives in Australia to ensure that they received good, appropriate and sensitive feedback about a family member. The consultant had a very good knowledge of all the patients on the ward and could recite the individual needs of the patient and requests made by their families.

On every ward we visited Staff told us that ward managers were visible and approachable. We spoke to managers and they were able to communicate information with confidence and demonstrated sound knowledge of their areas. However, we visited one ward where there was no manager on duty and the most senior person was a band six nurse, who did not have all of the information requested.

Staff told us that there was a regular visit from an executive leader, on the oncology day unit. The staff were invited to meet the team and would send a ward representative to any board meetings if appropriate.

Staff knew about trust wide policies, such as the whistleblowing policy and were able to tell us about the review of all policies that was underway since the acquisition.

We were told that the oncology unit manager was supportive and led by example. They were enthusiastic and promoted development for all of the staff. Comments were made such as “I have never worked with a better manager”.

Before the acquisition in April 2018, both organisations had leadership development programmes and supported regional and national leadership programmes. Leads told us a leadership development group had been developed to understand and determine priorities for the new trust.

Vision and strategy
The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Staff told us that they understood the vision at a local level, but were not sure how it would change now that the trust had grown. They were positive about the strategy following the acquisition and thought it would not change greatly because the hospital had always had positive visions and goals.

We saw notices displayed around the areas we visited, describing the vision for the trust.
The trust communicated and displayed the vision as below;

**Vision:** To build healthier Lives

**Values:** Collaborative

Working in partnership with others to provide safe, appropriate care and improve outcomes.

**Honest**

Being transparent in all that we do, communicating openly, inclusively and with integrity.

**Accountable**

Taking personal and collective responsibility for the way in which we deliver care.

**Innovative**

Being responsive, creative and flexible, always looking for ways to do things better.

**Respectful**

Treating everyone with compassion, dignity and professionalism.

Locally, at ward level, staff knew the main vision for the trust. Although they often could not describe the vision completely, they demonstrated during inspection that they tried to apply it in their daily work.

**Culture**

**Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

The staff at Solihull Hospital demonstrated a cohesive and caring attitude to their work. We saw that staff of all grades helped each other and in most cases called each other by first names. We found that senior staff had taken the time to know the names of all staff within their area.

All staff we spoke to could describe the importance of being open and honest with patients and their families. Although there were no records of duty of candour (DoC) training available, staff told us that DoC was discussed at ward meetings.

Patients spoke highly of the hospital and its staff. There was a local interest in the hospital and comments we heard all described a “family feel”. This contributed to the overall positive culture that we saw during our visit.

Most staff, particularly volunteers, would ask people if they needed help and gave a feeling that nothing would be too much trouble. There was a sense that security was important and on many occasions inspectors were asked for identification, before entering wards and whether we needed help in finding our way.

We spoke with new members of staff and they told us that they had been welcomed into the hospital. One nurse told us that all the staff on the ward had introduced themselves on their first day and welcomed them onto the ward. This included the consultant and doctors along with healthcare assistants and domestic staff.

We spoke with a member of domestic staff who told us that they felt part of the team and were treated as an equal member. They said that they “loved” working on ward 20A, and on occasions when they worked elsewhere, they had been treated the same. They said that the culture at the hospital was positive and that everyone cared about the patients.

**Governance**
The service used a systematic approach to continually improve the quality of care. The governance structure was embedded. However, we were told that a review of all processes was under way following the acquisition to develop a consistency across all sites.

Monthly division 4, clinical governance meetings were held. We reviewed the minutes, which showed that agenda items included items such as the risk register, clinical audits, incidents, serious incidents, patient experience and mortality were discussed and concerns and actions noted. The meetings had good representation from a variety of staff groups to ensure a consistent input from relevant specialists.

There were monthly ward meetings scheduled and staff could discuss issues and themes around incidents, performance and data or training and development ideas.

We were told that there was a review ongoing, around sepsis management across the trust, aiming to align the processes, following the recent acquisition (April 2018).

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them. Senior leaders knew what was on their risk registers.

Risk registers were available at ward, divisional and trust level. Managers knew what was on their risk register and how it contributed to the overall trust wide risks. In some areas, such as the oncology day unit and ward 8 stroke care ward, managers could tell us what they considered a risk and if it was on a risk register. We were given an example of the security of the pharmacy room door, not being adequate, especially when there were no staff in the room. This had been raised as a risk and subsequently an action plan put in place to rectify or mitigate. During inspection we saw that the lock had been changed to a numbered key pad.

There was a quarterly compliance and assurance report compiled to highlight any concerns or strategic risks, that needed to be escalated to the Board Assurance Framework (BAF) which identified serious trust wide concerns.

We saw that, since acquisition in April 2018, there was a focus on aligning performance and monitoring processes, to provide cross site consistency across the trust. There was a national and local clinical audit plan and results, action plans and risks were discussed at monthly divisional governance meetings.

Concerns were escalated to the board through the divisional management team and contribution to the board reports and development of a division 4, medicine service business plan.

The divisional leads could describe the risks on the division 4 risk register, which included, workforce vacancies, upgrade of IT system and delayed transfer of care.

**Information management**

The service collected, managed and used information well to support all its activities, using secure electronic systems.

Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible through the trusts intranet facility.

The IT teams and systems, were being reviewed to ensure a consistency in processes across the trust. This was to consider what would work best in each area and combining or replacing systems to ensure efficiency, safety and consistency in the systems used by the trust. The email system was the first to be updated in order for comprehensive communication to be made available to all staff employed by the trust.
Patient information was mostly kept safe and secure and suitably managed. Patient records were transported and secured using trollies. However, we saw that two of them had locks that were broken. Staff told us that these were awaiting repair.

Senior leaders, including ward managers demonstrated good understanding of performance across the medical areas and how performance and patient and staff feedback, were used inform actions to improve services. For example, the improvement in seating for patients waiting areas, was a direct result of a complaint.

**Engagement**

**The service engaged well with patients and staff.**

During the inspection, staff told us that they had seen new information displayed around the hospital with changes to personnel and names of executives on them. Most staff we spoke to said that they had not met the CEO (Chief executive officer). However, they received updates through e-mails and felt well informed.

We saw copies of the recent news@UHB paper that was specific to Solihull Hospital and Community Services. The publication provided relevant information about the hospital along with good news stories and information about the trust.

Staff across the hospital had raised money for the hospital charities and on ward 8, we saw that there had been a range of activities such as, book sales, cake sales and entertainment events put on to raise funds.

Building Healthier lives awards – division 4 which includes medicine at Solihull Hospital, had received the highest number of nominations across the trust.

Staff had been involved in planning the new oncology unit and their suggestion for providing an alternative exit to avoid walking through the waiting room had been implemented.

We saw many cards across different areas, thanking the manager or complimenting the staff for the care that had been given. In one area all compliments and cards were scanned into the computer and then emailed to staff to share the information. This included some senior managers who had requested that the information be shared across the organisation.

**Learning, continuous improvement and innovation**

Trust wide training about people living with dementia and managing their stay in hospital had been introduced. These were known as compassionate masterclasses and staff could improve knowledge and make pledges to work differently, when dealing with someone having dementia or similar conditions. This included simple pledges such as, asking people their name, asking how they are and understanding what is important to individual patients.

We saw a garden attached to ward 8 that was designed to support patient’s recovery. The area was maintained by the trust estates department and funded by the local garden centre that supplied equipment and plants to support the ward with the rehabilitation process. There was a portable garden that was designed to be wheeled under cover in case of inclement weather. The garden area also had games that patients could utilise in the open environment and chairs and tables for relaxing and eating, where appropriate.

There was also a relative’s room that had been funded and supported by a well-known department store, that provided comfortable seating and pleasant decorations for the families of patients to use.
There was an older person's assessment and liaison (OPAL) team that had been set up to provide specialist advice and support to patients and staff.

Staff were consulted about the development and construction of the new (May 2018) oncology day unit at Solihull Hospital. As a result of consultation an extra door was fitted to the patient “quiet room” in order to create an exit to the unit which stopped the need for patients and family having to go out through the waiting room area. This allowed distressed or upset family members or patients to have privacy and avoid further distress.

On some wards there were certificates given monthly to staff that had been nominated by patients or other staff, for their contributions. These could be extra care or time spent with a patient or support for another member of staff. The staff told us that there was a sense of pride achieved when receiving an award that had been nominated by the people they worked with or patients and families.

We were told that divisional leads were introducing skype calls to improve the way time was managed around trust wide meetings. This initiative was suggested to reduce the travel to and from different sites, particularly with the increase in geographical footprint since the acquisition.

Divisional leads showed us the 2018-2020, division 4 medicine business plan which linked to the core service values and the trust values.

The trust launched a “Board of Directors” unannounced governance visit programme in June 2018. This allowed senior team members to assess and contribute to the work being done at ward level.
Surgical services at the University Hospitals Birmingham NHS Foundation Trust are provided at the Queen Elizabeth hospital, Good Hope hospital, Heartlands hospital and Solihull hospital. This evidence appendix focuses on surgical services provided at Solihull hospital. Surgical services at the other sites are reported in separate evidence appendices.

However, as the management team also have responsibility for services at Good Hope hospital and Heartlands hospital and some staff also provide care and treatment at these sites, there are inevitably some elements of the report that are the same across each of the three sites.

Solihull hospital has two surgical wards, a day procedures unit and operating theatres. At the time of the inspection, emergency surgery was not undertaken at the Solihull site. All surgery was planned surgery.

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

A site breakdown can be found below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Hope Hospital</td>
<td>Ward 14</td>
<td>Elective orthopaedics and trauma</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 15</td>
<td>Elective orthopaedics and trauma</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 16</td>
<td>Elective/emergency colorectal surgery</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Ward 17 SAU</td>
<td>Surgery assessment unit/general surgery</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td><strong>Total beds</strong></td>
<td></td>
<td><strong>108</strong></td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>Ward 4</td>
<td>Elective/emergency thoracic and vascular surgery</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Ward 5</td>
<td>Elective/emergency ENT/general surgery</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Ward 8</td>
<td>Acute trauma and rehabilitation</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Ward 9</td>
<td>Acute trauma and rehabilitation</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Ward 10</td>
<td>Elective/emergency urology and urology treatment centre</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Ward 11 SAU</td>
<td>Surgery assessment unit/general surgery</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Ward 12</td>
<td>Elective/emergency colorectal surgery</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td><strong>Total beds</strong></td>
<td></td>
<td><strong>207</strong></td>
</tr>
<tr>
<td>Queen Elizabeth Hospital Birmingham</td>
<td>Admissions lounge</td>
<td>Elective surgical admissions</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Ambulatory care services</td>
<td>Day case and short stay surgery</td>
<td><strong>81 trolleys</strong></td>
</tr>
<tr>
<td></td>
<td>Anaesthetics</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Site</td>
<td>Ward</td>
<td>Specialty</td>
<td>Beds</td>
</tr>
<tr>
<td>--------------</td>
<td>------</td>
<td>----------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Theatres</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ward 305</td>
<td>-</td>
<td>General surgery/vascular surgery</td>
<td>36</td>
</tr>
<tr>
<td>Ward 306</td>
<td>-</td>
<td>Cardiac surgery</td>
<td>36</td>
</tr>
<tr>
<td>Ward 409</td>
<td>-</td>
<td>Neurosurgery</td>
<td>36</td>
</tr>
<tr>
<td>Ward 410</td>
<td>-</td>
<td>Trauma</td>
<td>36</td>
</tr>
<tr>
<td>Ward 412</td>
<td>-</td>
<td>Trauma</td>
<td>36</td>
</tr>
<tr>
<td>Ward 620</td>
<td>-</td>
<td>Surgical assessment unit</td>
<td>36</td>
</tr>
<tr>
<td>Ward 624</td>
<td>-</td>
<td>Urology/ENT/MaxFax/plastics</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total beds</strong></td>
<td>252</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Solihull Hospital | Ward 14 | Elective urology/general surgery and urology daycase/treatment centre | 14   |
| Solihull Hospital | Ward 15 | Elective orthopaedics                                            | 33   |
| **Total beds**    | 47     |                                                                    |      |

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provides two nationally commissioned transplant programmes:
- Heart / lung
- Liver

Birmingham Heartlands Hospital hosts the regional thoracic surgery service and is home to the vascular hybrid operating theatre.

(Source: Acute Provider Information Request – Context acute tabs)

**University Hospitals Birmingham NHS Foundation Trust**

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

The trust had 46,812 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 14,392 (30.7%), 23,026 (49.2%) were day case, and the remaining 9,394 (20.1%) were elective.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust had 59,370 surgical admissions from April 2017 to March 2018. Emergency admissions accounted for 19,116 (32.2%), 33,370 (56.2%) were day case, and the remaining 6,884 (11.6%) were elective.

(Source: Hospital Episode Statistics)

A range of surgical specialties provide surgical services at Solihull hospital, including general surgery, urology, breast, orthopedics and ophthalmology.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training completion levels exceeded trust targets for both medical and nursing staff.

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Solihull Hospital

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>80</td>
<td>80</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>80</td>
<td>80</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>80</td>
<td>80</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>80</td>
<td>80</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>77</td>
<td>78</td>
<td>98.7%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management</td>
<td>78</td>
<td>80</td>
<td>97.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>78</td>
<td>80</td>
<td>97.5%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>76</td>
<td>78</td>
<td>97.4%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>77</td>
<td>80</td>
<td>96.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>76</td>
<td>80</td>
<td>95.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>76</td>
<td>80</td>
<td>95.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>71</td>
<td>78</td>
<td>91.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall training compliance rate of 97.4% for qualified nursing staff. The trust’s 90% completion target was met for all 12 mandatory training modules for which qualified nursing staff were eligible.
A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for medical staff in surgery at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>1</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>1</td>
</tr>
<tr>
<td>Medicines management</td>
<td>1</td>
</tr>
<tr>
<td>Infection prevention and Control</td>
<td>1</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>1</td>
</tr>
<tr>
<td>Fire safety</td>
<td>1</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>1</td>
</tr>
<tr>
<td>Manual handling – patient handling</td>
<td>1</td>
</tr>
<tr>
<td>Information governance</td>
<td>1</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>1</td>
</tr>
<tr>
<td>Waste management</td>
<td>1</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>1</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall training compliance rate of 100.0% for medical staff. The trust’s 90% completion target was met for all 12 mandatory training modules for which medical staff were eligible. This relates to only one member of staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust used an electronic system to record staff completion of mandatory training. Senior ward sisters told us they could check online whether their staff were up to date with their training and see reports for their area. The system provided email alerts when staff were nearing their renewal date and if staff did not attend booked training, the senior sister received an alert to notify them.

Staff told us they were reminded when their training was due and said that it was easy to access the training.

Senior sisters told us, and we saw from their data, that compliance with mandatory training for their wards was good and totals were above the trust target of 90%. For example, at October 2018, ward 14 had a compliance of 96%, ward 15 had a compliance of 95% and theatres had a compliance of 97%. The data provided by the trust confirmed this and that medical staff also completed mandatory training in line with the trust targets.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had a good knowledge of their responsibilities to report safeguarding concerns and make referrals. They were supported by the trust safeguarding team to do this.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request
spreadsheets, to be completed within a standard template.

Though the trust has reported figures for safeguarding level 1 training, it should be noted that the trust has not designated this as mandatory training.

**Solihull Hospital**

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>80</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>78</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall safeguarding training compliance rate of 100.0% for qualified nursing staff. The trust’s 90% completion target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for medical staff in surgery at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding level 2 children and adults/ DoLs and mental capacity</td>
<td>1</td>
</tr>
</tbody>
</table>

In surgery, the hospital had an overall safeguarding training compliance rate of 100.0% for medical staff. The trust’s 90% completion target was met for both safeguarding training modules for which medical staff were eligible. This relates to only one member of staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Trust training included PREVENT awareness. PREVENT is one of the arms of the government’s anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation.

Awareness of female genital mutilation (FGM) was included in safeguarding training and staff had knowledge of the issue. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

The trust had policies for safeguarding adults and children and these were available to staff on the trust intranet. A flow chart detailing action staff should take and the referral process, was provided
by the trust safeguarding team. We saw this was displayed in some of the clinical areas and staff told us they found it very useful.

Nursing staff were aware of the names of the safeguarding team and how to contact them. They said that if they required advice, a member of the team was available and would provide advice over the telephone. Each ward had a safeguarding champion or link nurse. These staff had attended additional training to enable them to provide advice to staff on the ward, if there was a query. An adult safeguarding newsletter was produced on occasions by the trust safeguarding team and staff found this useful.

Several staff gave us examples of occasions when they had reported a safeguarding concern and made a referral. They told us they made an electronic referral to the local authority safeguarding team and also notified the trust safeguarding lead. This provided us with assurance that staff were aware of the signs of abuse and the action they should take. They said they usually received feedback following a referral.

We saw information for patients about adult safeguarding was displayed at the entrance to ward 15 along with information about advocacy services.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Audits were completed to ensure staff adhered to national guidance.

The trust had systems in place for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

From October 2017 to September 2018 the trust reported no toxin positive Clostridium difficile (C. difficile) infections and one gene positive infection in surgery at Solihull hospital (Ward 15). There were no Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia’s reported in the same period.

We saw completed records for pre-operative assessments including MRSA screening on the surgical wards at Solihull hospital in all the care records we reviewed.

Patient records we looked at, had been completed consistently with regards peripheral venous catheter (PVC) insertion and care as per the National Institute for Health and Care Excellence (NICE) QS61 guidance. We also observed the insertion of a cannula in theatre where the necessary personal protective equipment (PPE) was worn, and a sterile pack was used. trust audits showed 100% compliance with the peripheral cannula insertion and ongoing care procedures on ward 14 in September 2018. No data was available for ward 15 in September 2018. Adherence to these procedures are important in the prevention of healthcare associated infections.

The hospitals in the former Heart of England NHS trust which included Solihull hospital, submitted data for the national surgical site infection (SSI) audits for 2016/2017 for repair of fractured neck of femur and data showed the percentage of patients developing an infection was in line with other trusts. They did not submit data for the SSI surveillance programme for hip or knee prosthesis. However, they sent us a copy of work they had been undertaking to investigate and improve surgical site infections in orthopaedic surgery. The trust also had an extended scope practitioner referral pathway for prosthetic joint infection. In addition, the colorectal surgical speciality completed a local surgical site infection audit. The results of this are reported under patient outcomes in this evidence appendix.
Hand gel was readily available at the end of all beds and handwashing facilities were available in all clinical areas. During the inspection we observed good compliance with hand hygiene procedures and the trust’s ‘bare below the elbows’ policy. We observed nursing staff using hand sanitiser between patients and before finishing their duties. We also observed staff handwashing when patients were handed over from the theatre to recovery as per NICE QS61 guidance. Data provided by the trust indicated 100% compliance for ward 14, ward 15, main theatres and ophthalmology theatres, in the months when hand hygiene audits were undertaken, from April 2018 to September 2018.

Personal protective clothing and equipment (PPE) were available within clinical areas and we observed staff using them when providing care. Staff in the operating theatres wore the correct attire with hats covering their hair, appropriate theatre footwear and face masks. Staff followed the surgical hand asepsis technique and donned gowns and gloves using the sterile technique as per NICE CG74 guidance.

All equipment we checked was labelled with ‘I am clean’ stickers dated that week. All surgical ward curtains surrounding beds were disposable and the six curtains we checked, were all replaced within the last six months, as per guidance. Bathrooms checked were visibly clean, accessible and tidy.

We saw signed and up to date cleaning schedules in the on both wards. However, we could locate no previous weekly cleaning schedules before 8 October 2018 in ward 15. The daily and weekly cleaning records within the operating theatres also had gaps.

Patients we spoke with felt that surgical wards were kept clean and praised the work of domestic cleaning staff, stating “there’s set things for them to do each day and they stick to it”. Another patient confirmed they usually had handwipes on their bed table and trays at mealtimes.

Environment and equipment

Our inspection identified some concerns with the suitability of the premises and equipment and maintenance. The airflow exchange in parts of the operating theatres did not meet with Department of Health guidance. Storage areas were limited and some pieces of equipment were found in corridors and spaces designed for patients. Equipment suitable for the care of bariatric patients was not available at Solihull hospital and therefore equipment had to be supplied from another of the trust hospital sites, or the patient cared for at an alternative site. We found some consumables stored on the wards that were past their expiry dates and a resuscitation trolley in the day procedures unit was not always checked daily when the unit was operational.

The surgical wards and the day procedures unit had secure entry systems to enable staff to monitor people entering and leaving the wards. Visitors gained access by ringing a bell by the entrance to the ward. The wards were arranged in six bedded bays, with a small number of single rooms. Piped oxygen and suction equipment was available at each bed space, as well as call bells for patients and for emergency use. Curtains used to surround each bed space were disposable and those we checked had been replaced within the previous six months. This is in line with accepted practice. There were sufficient toilet and bathroom facilities which were designated as single sex in line with Department of Health guidance and adapted for the safety of patients with a disability.

Storage areas on the wards and in the day procedures unit were limited. We observed equipment including beds were stored in the corridors on a temporary basis and pressure relieving equipment that had arrived or was awaiting collection was stored in the corridors. The day procedures unit
shared the discharge area with endoscopy and we observed this area was used to stored
equipment, including a hoist and imaging equipment.

There was sufficient equipment such as vital signs observation equipment, commodes and moving
and handling equipment, on surgical wards to meet patient’s needs. Alternating pressure
mattresses and pressure relieving cushions, used for patients at risk of developing pressure
ulcers, were supplied through a contract with an external manufacturer. Staff told us they were
supplied in a timely manner and normally within two hours of the request being placed.

There was no equipment at the Solihull hospital, suitable for bariatric patients. Staff told us, that if
bariatric equipment was required, it would be obtained from a neighbouring hospital in advance.
Staff on the day procedures unit said they did not admit bariatric patients, as their trolleys were not
suitable.

The trust had arrangements for the maintenance of medical devices in accordance with the
Medicines and Healthcare products Regulatory Agency (MHRA) Managing Medical Devices (April
2015), and other national guidance. Equipment we checked, showed that it had been serviced and
tested for electrical safety, within the previous 12 months. However, we found some consumables
such as catheters, tracheal tubes and blood spillage kits which were stored on the wards and were
past their expiry date. We brought these to the attention of the senior sisters as applicable and
they agreed to dispose of them.

Resuscitation equipment was stored in resuscitation trolleys in each clinical area. The trolleys did
not have tamper proof drawers; however, all equipment was stored in plastic wrapped packs which
were sealed and it would be evident if the packs were opened. Staff recorded daily checks of the
resuscitation trolleys on the wards. However, we noted there were five days in September and
October 2018 when a resuscitation trolley was not checked in the day procedures unit when the
unit was operational. Resuscitation equipment in other areas was checked daily.

Operating theatres also had trolleys prepared for other emergency situations, such as a ‘difficult
airway’ trolley. These were checked daily. Theatre staff told us the theatre packs containing
instruments for surgery were provided daily and could be ‘fast tracked’ in 4 hours if necessary. We
spoke with a patient who was re-scheduled from another hospital within the trust, to Solihull
hospital during the inspection. They said staff had told them their surgery could only go ahead that
day, if staff were able to obtain some equipment from the neighbouring hospital. We checked with
staff and they confirmed theatre packs had to be obtained from the neighbouring hospital and had
been requested. During the inspection they confirmed the necessary packs had been obtained
and the surgery would go ahead.

Electrical equipment in the operating theatres showed evidence of regular servicing and
maintenance. However, we observed the waterproof covering of some equipment such as a head
support and theatre stool were worn and underlying foam exposed, increasing the risk of the
transmission of infection. We raised this with the theatre manager who immediately ordered a new
head support.

A contract was in place with an external supplier for the sterilisation of theatre instruments and
trays. These were mostly processed in a timely manner. However, theatre staff (band six) were
responsible for checking and arranging the repair or replacement of instruments as required.
Although this did not create safety issues, alternative arrangements would enable theatre staff time to be used more effectively, particularly in view of the volume of staff vacancies in the department.

The trust used an external contractor to verify theatre airflow rates for the operating theatres at Solihull hospital. These were reported in August 2018 and indicated issues with theatre airflow rates and a lack of compliance with Department of Health guidance for operating theatres (HTM03-01). The contractor indicated the timescale for addressing these issues should be one month. We did not receive any information from the trust to indicate the issues were resolved.

Assessing and responding to patient risk

Staff did not always complete the necessary risk assessments for each patient. Assessment of patient’s risk of venous thrombo-embolism (VTE) were not consistently completed. Staff adherence to the use and principles of the surgical safety checklist was variable and could be improved. The consistent use of the checklist is key to eliminating surgical errors.

Patients admitted for elective (planned) surgery attended a pre-operative assessment and staff assessed their individual risk, in line with guidance on pre-operative assessment from the modernisation agency. A standard proforma was used by staff, to ensure a consistent approach was taken. The trust applied some restrictions to the patients booked for surgery at Solihull hospital, due to the limited high dependency beds available. The service used the American Society of Anaesthetists (ASA) classification system to grade a patient’s level of risk and plan the patients care accordingly. Patients with a higher level of risk were directed to other trust sites as necessary to maintain patient safety. When additional risks were identified, staff in the pre-assessment clinic referred the patient to an anaesthetist for further review. Staff told us an anaesthetist had previously attended the clinic on a regular basis and provided input and this no longer occurred. They said they could bleep an anaesthetist if necessary; however, regular input of an anaesthetist would be beneficial for patients and reduce delays.

Medical and nursing staff completed risk assessments when patients were admitted for surgery. Nursing staff used standardised tools to assess patient’s risk of developing pressure ulcers, falls, nutritional risk and risks associated with moving and handling. These risks were reviewed regularly. Where patients were identified as being at risk, plans to reduce the risks were in place. For example, when patients were at risk of developing a pressure ulcer, pressure relieving equipment was used and the patient was assisted to change their position on a regular basis. Nursing staff used a care bundle to record re-positioning and other interventions to prevent pressure ulcers developing.

NICE guidance (NG89) published in March 2018 states that all surgical and trauma patients should be assessed to identify the risk of VTE (venous thrombo-embolism or blood clots) as soon as possible after admission to hospital, or by the time of the first consultant review and that reassessments for VTE should be at the point of consultant review, or if their clinical condition changes. VTE risk assessments were completed electronically, in conjunction with the electronic prescribing system. Two of the five VTE risk assessments we checked, had not been completed within 24 hours of admission. Nursing staff told us the doctors were responsible for completing the VTE risk assessments; however, nurses were taking more responsibility for ensuring they were completed and had undertaken training on VTE.

Data provided by the trust showed between 82% and 98% of patients on ward 14 had VTE assessments completed on admission from September 2017 to August 2018. Ward 15 scored between 93% and 100% in the same period except for in December 2017 when 78% of patients were assessed.

Nursing staff completed a pre-operative checklist to ensure the required safety checks were made prior to the patient’s transfer to theatre and we observed a detailed handover taking place for two
patients we followed to theatre. The required identity and other safety checks were completed when the patient was handed over to theatre staff.

We observed the order of the ophthalmic theatre list was changed prior to the start of the list. This was documented on the operating list and the operating list was re-printed as per best practice recommendations published by the Association for Peri-operative Practice.

To reduce and potentially eliminate errors occurring in the operating theatre, the trust used the World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. However, when we observed the use of the checklist in the operating theatres during the inspection, we found variable adherence to the principles and practices. For example, in the ophthalmic theatres, not all elements of the ‘time out’ stage were read out loud (the checklist specifically stated that it should be read out loud). In the main theatres, we observed the anaesthetist was speaking with the anaesthetic junior during ‘sign out’ and the operating department practitioner and circulator were not present. The trust proforma states that it should be completed before any member of the team leaves theatre.

The trust told us compliance with the WHO checklist was audited by three different approaches. Firstly, checklist compliance was audited for every checklist in the trust to ensure that the checklist had been adequately completed and these figures were reported monthly to the trust's clinical quality monitoring group. Secondly, compliance in terms of comparison between number of operations performed and number of checklists completed, was monitored quarterly. These two steps ensured the checklist was completed for every operation. Lastly, they said an observational audit was undertaken six monthly to provide a qualitative aspect to auditing WHO compliance; this involved staff directly observing the completion of the WHO checklist in theatres. This did not correlate with feedback we received from staff.

We asked staff about observational audits of the use of the surgical safety checklist. They told us they had just started to introduce observational audits whereby staff from one hospital site audited another of the trust sites. The manager from Solihull hospital had audited practice at one of the other sites, however, an audit had not been undertaken at Solihull hospital. They told us band six theatre staff had recently had a training day and one of the consultant surgeons had given a presentation on the WHO checklist. Given the never events at some of the other trust sites over the previous 18 months, it was of concern that there had not been a previous focus on compliance with the checklist on a more regular basis.

We observed the ‘Stop before you block’ procedure being adhered to in theatres prior to the administration of a regional anaesthetic in accordance with patient safety guidelines.

Ward staff used the modified early warning score (MEWS) when they completed vital signs observations to identify deteriorating patients. This is in line with national guidance. The MEWS documentation included clear directions for staff on the action they should take if the MEWS score increased, indicating the patient’s condition was deteriorating. We checked the observation charts for eight patients and found the MEWS score was recorded with every set of observations. In instances when the score had increased, staff had taken action to alert the doctors or critical care outreach team to the issue. Notes written by medical staff and the critical care outreach team, indicated the patient was reviewed in a timely manner following escalation.

Data collected by the Matrons as part of the monthly ward performance metrics showed 100% compliance with referral of MEWS of 4 and above and sepsis screening of those patients, for wards 14 and 15 from September 2017 to September 2108

Nursing staff we spoke with, were aware of the action they should take when a patient’s MEWS score rose. They told us doctors were generally responsive when a concern was escalated to them; however, if they had difficulty in obtaining a response, they contacted the critical care outreach team who always responded quickly.

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. The trust had a sepsis protocol and used the national ‘Sepsis 6’ pathway to identify and treat sepsis. Managers told us sepsis training was included in the
training provided on MEWS. Data provided by the trust (DR191) showed sepsis training was provided as part of the new staff induction training in 2017 and 2018, although only three nurses from the surgical wards had attended the training.

Staff we spoke with were aware of the importance of identifying possible sepsis and providing interventions in a timely manner. We noted that the vital signs observation charts prompted staff to consider the possibility of sepsis when the MEWS score increased. We noted that charts had been completed to document interventions in relation to sepsis.

The senior management team for surgery told us they were in the process of developing Local Safety Standards for Invasive Procedures (LocSSIPs) in line with national guidance. The minutes of some of the specialty governance meetings showed they were being developed and discussed. In addition, the trust provided us with a copy of some of the LocSSIPs following the inspection. However, staff in theatres were unaware of the initiative and of the progress being made.

**Nurse staffing**

The service had enough nursing and theatre staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, vacancies on ward 15/16 resulted in sub-optimal staffing levels and the requirement to use temporary staffing.

The trust used the national safer nursing care tool to review and set their nurse staffing levels. Staff told us the tool was used annually and when there was a change in the ward which might influence staffing requirement. Senior sisters we spoke with felt their planned staffing levels reflected the staffing requirements and said they had received uplifts in staffing in the past when the tool and their professional judgement indicated additional staff were required.

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified nursing staff in surgery.

The overall fill rate for qualified nursing staff dropped from 87.4% in March 2018 to 74.8% in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>1,199.7</td>
<td>1,268.6</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>291.9</td>
<td>399.7</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>79.5</td>
<td>111.3</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>163.3</td>
<td>203.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staff tab)

At Solihull hospital, in main theatres, staff told us they had previously had vacancies for nurses and operating department practitioners (ODPs); however, the vacancies were now filled albeit they were waiting for some newly recruited staff to commence work. The impact of the previous vacancies had been mitigated by the use of regular bank and agency staff. As a result, they were meeting the standards for staffing levels in theatres published by the Association for Perioperative Practice (AfPP). We were told that the theatre staffing levels were under review at the time of the inspection, as there was no allowance within the staffing budget for absence due to
sickness or training.

Planned and actual nurse staffing levels were displayed on a board within each ward. We reviewed these during the inspection and saw that in most instances the planned levels were met.

Staff in the day procedures unit told us they had six whole time equivalent (WTE) nurse and ODP vacancies; however, they were generally able to fill the rota through the use of bank staff.

Staff on ward 14 told us they had no vacancies at the time of the inspection and frequently supported other wards when others were short staffed. The trust were proposing a move to seven day working for ward 14 which, at the time of the inspection, was not open from Saturday afternoon until Monday morning. They recognised that more staff would be required when this occurred and the nursing management team were reviewing this.

Ward 15/16 had 12 registered nurse vacancies at the time of the inspection. They told us they were reviewing vacancies and strategies for recruitment within the trauma and orthopaedic directorate as a whole. The matrons reviewed staffing levels on a daily basis and moved staff from other areas when possible to support the ward. Senior nurses described initiatives such as the development of the associate nurse role, open days and other trust wide initiatives that were being undertaken, to overcome the shortage of registered nurses.

Agency staff were orientated to the ward on their first shift and the nurse in charge went through policies and procedures with them. Staff told us they received a comprehensive handover at the start of each shift and we saw a printed handover sheet which contained key information about each patient and their specific care needs.

Nurse vacancies was identified as a risk on the divisional risk register and a committee was overseeing recruitment initiatives.

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 8.7% for qualified nursing staff in surgery. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital, but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 2.8%
- Birmingham Heartlands Hospital: 20.4%
- Good Hope Hospital: 12.9%
- Solihull Hospital: 14.7%

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*
Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 5.0% for qualified nursing staff in surgery. This is above the trust targets of 3.6% for Queen Elizabeth Hospital, and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

- Queen Elizabeth Hospital: 5.7%
- Birmingham Heartlands Hospital: 3.6%
- Good Hope Hospital: 5.0%
- Solihull Hospital: 4.8%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From April 2017 to March 2018 the trust reported 5,841 shifts were filled by agency staff, 40,015 by bank staff and 23,539 shifts were left unfilled.

A breakdown by site is below:

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Bank</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>2,468</td>
<td>34,240</td>
<td>19,211</td>
</tr>
<tr>
<td>Other sites</td>
<td>3,373</td>
<td>5,775</td>
<td>4,328</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm. However, there were challenges in relation to junior medical staffing and the high use of temporary staff.

The trust has reported their staffing numbers below for March 2018 and June 2018 for medical staff in surgery.

The overall fill rate for medical staff dropped from 94.9% in March 2018 to 90.9% in June 2018. Solihull Hospital has a particularly low rate, with only one member of staff in post out of a planned five in June 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th></th>
<th></th>
<th>June 2018</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
<td>Fill Rate</td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>586.6</td>
<td>556.3</td>
<td>105.5%</td>
<td>774.6</td>
<td>805.2</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>254.9</td>
<td>335.0</td>
<td>76.1%</td>
<td>256.0</td>
<td>350.7</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>102.0</td>
<td>100.0</td>
<td>102.1%</td>
<td>100.0</td>
<td>95.8</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>1.0</td>
<td>4.0</td>
<td>25.0%</td>
<td>1.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>
Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

Turnover rates

From April 2017 to March 2018, the trust reported a turnover rate of 7.0% for medical staff in surgery. This is below the trust target of 8.5% for Birmingham Heartlands Hospital and Good Hope Hospital.

The trust reports that it does not have a set target for Queen Elizabeth Hospital but monitors turnover for trends and spikes and benchmarks the activity.

A breakdown by site is below:

- Queen Elizabeth Hospital: 4.6%
- Birmingham Heartlands Hospital: 9.5%
- Good Hope Hospital: 15.5%

Sickness rates

From April 2017 to March 2018, the trust reported a sickness rate of 1.1% for medical staff in surgery. This is below the trust targets of 3.6% for Queen Elizabeth Hospital, and 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital, Solihull Hospital and their community locations.

A breakdown by site is below:

- Queen Elizabeth Hospital: 1.0%
- Birmingham Heartlands Hospital: 1.4%
- Good Hope Hospital: 0.6%
- Solihull Hospital: 9.1%

The rate for Solihull is above the target of 4.0% for this site, but relates to a small number of staff.

Locum and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data for the total number of planned shifts and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

From April 2017 to March 2018 the trust reported that 10,444 shifts were filled by agency medical
staff, 8,034 by locum medical staff and that 1,292 were left unfilled.

<table>
<thead>
<tr>
<th>Site</th>
<th>Agency</th>
<th>Locum</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>4,831</td>
<td>1,736</td>
<td>747</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>3,948</td>
<td>2,969</td>
<td>386</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>936</td>
<td>2,425</td>
<td>105</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>729</td>
<td>904</td>
<td>54</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

### Staffing skill mix

In May 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

### Staffing skill mix for the whole time equivalent staff working at University Hospitals Birmingham NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>53%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>10%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Surgical consultants in each specialty were present on the site daily and provided on call cover out of hours. Most surgical consultants cared for patients on other trust sites in addition to Solihull. We spoke with three junior doctors including a locum. They told us the consultants were contactable and were very responsive to requests for advice.

At Solihull hospital, junior doctors covered the surgical wards from 8am to 5pm. The division had introduced a twilight shift to provide junior doctor cover for surgery until 9pm. Between 9pm and 8am the surgical wards were covered by the medical foundation year doctors and registrar. If surgical advice was required it was provided by the surgical registrar at the neighbouring hospital and there was a consultant on call.

A senior nurse told us the number of junior doctors available on the wards was not consistent and temporary staff were used, creating challenges with continuity of care and their knowledge of trust policies and practices. They told us the rota was not always correct and, due to the fact the doctors were covering all the surgical wards, there were delays and difficulties in contacting them. A junior doctor described the rota management as chaotic at times, as they were moved from site to site on a day by day basis. Medical staffing was identified as a risk on the divisional risk register.
The surgical division had explored options to supplement the numbers of junior doctors. This included recruiting non-training junior doctor roles, including recruiting international training fellows. In addition, they were developing advanced care practitioner roles in most specialties. Advanced care practitioners (ACPs) are staff who have completed formal training to enable them to undertake most elements of the junior doctor role. An ACP said the intention was to provide continuity of care, however they found themselves working on different sites on a day to day basis. The senior management team told us they had identified initial challenges in the utilisation of advanced care practitioners and were currently re-designing the service with the involvement of one of the first ACPs to be appointed. They recognised that initially, they were used to bridge the gaps in staffing and this was not ideal. Following a General Medical Council survey, they had been rigorous in addressing the induction process for medical staff. An international doctor told us they had been allocated shadow shifts for the first month and they had a mentor. They felt well supported. The senior management team said the education committee were overseeing the initiatives.

An ortho-geriatrician visited the surgical wards to attend handover and review patients, three times a week. They were also available for advice outside these times.

There was no formal handover between the medical staff covering the night and day. However, they told us they junior doctors would contact them at the start of the day shift if there had been any problems overnight.

**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, we found some omissions in nursing care plans for patients with additional nursing needs.

Staff had access to patients’ medical and nursing records. Records of the current hospital admission were stored in locked trolleys in each ward area and patients’ past medical records were stored separately in locked cupboards. Records of nursing assessments and daily nursing care were stored separately in folders by each patient’s bed. Therapies and other staff documented daily care in the medical records. This meant staff were able to access the information they required to provide safe care and treatment.

We reviewed 12 patient records. Entries were legible, dated, timed, signed and the designation of the person making the record was recorded, in line with required practice. Records of the pre-operative assessment and initial admission assessment were completed consistently. Records completed by medical staff gave a clear plan for the patient and the results of ongoing investigations. All members of the multi-disciplinary team made contemporaneous entries in the medical records and this enabled a clear picture of the patient’s progress to be gained. Nursing assessments were completed using a pre-printed surgical inpatient or day case surgery proforma. They contained risk assessments and care plans based on the level of risk to the patient. However, nursing care plans were not developed to plan care for patients with other health conditions, not associated with their surgery. For example, the dietary needs of patients with diabetes or swallowing problems, or the care of patients living with dementia. The nursing handover of key elements of each patient’s care was recorded electronically and all staff from the multi-disciplinary team had access to this. This hand over record did provide information to show a patient had diabetes or dementia and the key elements of their care in relation to this. Therefore, risks to patient safety were mitigated. It would however, mean that the information was not available at a future admission and was reliant on staff having access to the handover information.

Checklists such as pre-operative checklists and a discharge checklist were used to ensure a consistent approach, which improved patient safety. Observation charts were completed clearly and consistently, showing patients were reviewed on a regular basis.
On discharge from hospital, a summary of the admission and treatment provided was sent to the patient’s GP. The trust used an electronic system to produce the discharge summary and the order for medicines for the patient to take home. A copy of the discharge summary was sent electronically to the patient’s GP and the patient was given a copy to take home. Staff told us discharge summaries were produced before the patient left hospital.

**Medicines**

**Medicines were not always managed safely.** The temperature of refrigerators used for medicines storage on the wards were not monitored consistently and when they were above recommended limits, action was not always taken to report this to pharmacy. Systems in place for antibiotic stewardship were not fully established.

Medicines were stored safely in locked cupboards and refrigerators behind locked doors, or in restricted areas which were only accessible to authorised staff. Checks of the temperatures of the rooms used to store medicines were introduced the week prior to the inspection and had been checked daily in most cases. However, staff were not always clear about the recommended temperature limits and the action to be taken when the temperature exceeded the recommended limits. For example, room temperatures of above 25°C, were recorded in the medicines storage room on ward 14 since the introduction of the recording. Refrigerator temperatures with maximum/minimum readings were recorded; however, most staff we spoke with did not know how to reset these and when readings were above recommended limits, no action was taken. For example, the maximum temperature of a refrigerator on ward 15 was showing as 21°C and this was recorded on the record chart.

Medicines including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were stored securely and checked regularly in both the wards and operating theatres.

A medicines management technician spoke to patients where possible to carry out medicines reconciliation (checking the prescription for accuracy and completeness against the patient’s existing prescription and any medicines they brought in with them).

Medicines for use on the wards were prescribed and administered electronically. Nursing staff used the system to view the medicines which were due, and to record when they had given the medicine. Allergies and venous thrombo-embolism (VTE) assessments were also recorded on the system.

We checked five records and saw they were completed appropriately. However, the systems in place for antibiotic stewardship, to ensure antibiotics were used in line with national guidance, were not fully established. On ward 14 we found between 30% and 40% of antibiotics had a review date. The electronic prescription treated the review date as a stop date, so staff were reluctant to use it when they thought antibiotics may be required for a longer time period.

We observed staff administering medicines on most surgical wards and observed they followed safe practice. Patients told us staff checked their identity band or name and date of birth before administering their medicines. They told us staff explained their medicines to them and we heard a member of staff doing this with a patient.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents however, they did not always ensure that lessons learned were fully implemented. When things went wrong, staff apologised and gave patients honest information and suitable support.
Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From August 2017 to July 2018, the trust reported four incidents classified as never events for surgery:

- Wrong site surgery in October 2017 at Queen Elizabeth Hospital
- Wrong site surgery in November 2017 at Queen Elizabeth Hospital
- Wrong site surgery in April 2018 at Queen Elizabeth Hospital
- Retained foreign object in April 2018 at Good Hope Hospital

(Source: Strategic Executive Information System (STEIS))

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust reported one incident classified as a never event for surgery. This related to wrong site surgery and occurred at Birmingham Heartlands Hospital in October 2017.

No never events were reported in surgery at Solihull hospital from April 2017 to March 2018. Theatre staff were aware of previous never events within the other hospitals in the Heart of England NHS Foundation Trust such as the insertion of an incorrect implant or the retained foreign object. They told us the implant checklist was changed and changes to practice in relation to the implants taken into theatre had been implemented across the trust, to reduce the risk of a similar incident occurring in the future. There was no knowledge of the never event that had occurred at the Queen Elizabeth hospital site in April 2018 and learning from this.

However, despite the learning staff told us they had gained from the never events across the trust, we observed variable adherence to the surgical safety checklist. This is fully discussed in this evidence appendix under assessing and responding to risk.

Breakdown of serious incidents reported to STEIS

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 33 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England occurring from August 2017 to July 2018.
The breakdown by type of incident reported were:

- Surgical/invasive procedure incident with 11 (33.3% of total incidents)
- Slips/trips/falls with six (18.2% of total incidents)
- Pressure ulcer with five (15.2% of total incidents)
- HCAI/Infection control incident with five (15.2% of total incidents)
- Diagnostic incident including delay (including failure to act on test results) with two (6.1% of total incidents)
- Medication incident with two (6.1% of total incidents)
- Sub-optimal care of the deteriorating patient with one (3.0% of total incidents)
- Treatment delay with one (3.0% of total incidents)

Site specific information can be found below:

- Queen Elizabeth Hospital (August 2017 to July 2018): 23 incidents
- Birmingham Heartlands Hospital (April to July 2018): seven incidents
- Good Hope Hospital (April to July 2018): two incidents
- Solihull Hospital (April to July 2018): one incident

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from August 2017 to March 2018.
The breakdown by type of incident reported were:

- Pressure ulcer with eight (34.8% of total incidents)
- Slips/trips/falls with six (26.1% of total incidents)
- Surgical/invasive procedure incident with three (13.0% of total incidents)
- Sub-optimal care of the deteriorating patient with two (8.7% of total incidents)
- Diagnostic incident including delay with two (8.7% of total incidents)
- HCAI/infection control incident with two (8.7% of total incidents)

Site specific information can be found below:
- Birmingham Heartlands Hospital: 13 incidents
- Good Hope Hospital: eight incidents
- Solihull Hospital: two incidents

(Source: Strategic Executive Information System (STEIS))

The trust used an electronic reporting system for recording incidents and accidents and action taken as a result. Ward staff told us there was an open culture in relation to incidents; they were encouraged to report incidents and they were all able to enter the details of incidents, onto the electronic reporting system.

Most staff said they received feedback from incidents and changes to practice in relation to incidents. This occurred at ward meetings, or by email. Senior staff also said they discussed incidents at audit half day meetings.

Nursing staff told us of actions taken within the wards to reduce pressure ulcers and falls. These were the most commonly occurring incidents reported by the surgical wards. A root cause analysis was completed for all grade 3 and 4 pressure ulcers, with the involvement of the tissue viability nurse and the ward manager. A similar process was in place for fall with injury and the falls specialist nurse was involved.

From November 2014, trusts were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety
incidents and provide reasonable support to the person. Staff we spoke with were aware of the
duty of candour legislation and the importance of being open and transparent with patients and
families when mistakes were made. They were aware of the process from including apologising to
the patient, providing feedback on the outcome of the investigation and steps put into place to
reduce the risk of similar mistakes occurring in the future.

The trust reported that awareness of being open and the duty of candour requirements was
provided to staff at a number of training sessions. They said compliance was reported to divisions
and specialties to increase awareness of the duty or candour requirements. Information was also
available online.

Safety thermometer

The Safety thermometer is used to record the prevalence of patient harms and to provide
immediate information and analysis for frontline teams to monitor their performance in delivering
harm free care. Measurement at the frontline is intended to focus attention on patient harms and
their elimination.

Data collection takes place one day each month – a suggested date for data collection is given
but wards can change this. Data must be submitted within 10 days of suggested data collection
date.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS
Foundation Trust in this analysis. Because it related to the same legal entity we have used this to
form part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure
ulcers, falls with harm or new urinary tract infections in patients with a catheter from August 2017
to August 2018 for medical services as all incidents were reported under the core service ‘Other’.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no
more recent data was available. We only provided this for contextual purposes and it did not form
part of our judgement.

Data from the Patient Safety Thermometer showed that the trust reported 50 new pressure
ulcers, eight falls with harm and two new catheter urinary tract infections from August 2017 to
August 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers,
falls and catheter urinary tract infections at Heart of England NHS
Foundation Trust

![Graph showing prevalence rate of pressure ulcers, falls, and catheter urinary tract infections at Heart of England NHS Foundation Trust]
Total Falls (8)

Total CUTIs (2)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Please note that this includes data for April to June 2018 which were submitted post acquisition under the code for Heart of England NHS Foundation Trust.

(Source: NHS Digital)

Senior sisters on the surgical wards told us a rigorous process was in place for the investigation of pressure ulcers occurring after a patient’s admission to hospital. They told us of the most recent pressure ulcers and relevant details about the circumstances and patient risk factors. The wards used a care bundle to record care interventions to prevent pressure ulcers, such as regular re-positioning, and we saw records were completed showing that care was completed at the intervals indicated on the care plan. Records also indicated that the requirement for a pressure relieving mattress and/or cushion was identified on admission and equipment was provided in a timely manner.

Patients’ risk of falls was assessed during the pre-operative assessment process and this enabled a plan to be put into place on admission. Staff told us they provided an information leaflet to patients over 65 years of age to advise them on falls prevention strategies. Staff spoke about the importance of ensuring patients had suitable footwear and ensuring they were aware of the need to use their call bell to call for assistance when they first came back from theatre, in case they were unsteady on their feet.

Matrons told us the number of falls had reduced dramatically over the last two years. Data provided by the trust in the form of the ward quality metrics showed an increase in falls from February 2018 to April 2018 on ward 14. On ward 15 there was an increase in falls in December 2017 and January 2018, although after that date there was a downward trend in falls. Both wards were rated green in the metrics for falls in all but those months identified above, where falls rose.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Audits were completed to make sure staff followed guidance, however, there was a lack of audit of practice in theatres against the national standards for safe per-operative practice.
We reviewed a small sample of trust policies and guidelines and found these referenced national best practice guidance relevant to the subject. Staff were able to access national clinical guidelines from the National Institute of Health and Care Excellence (NICE). These were accessible from the trust intranet. Other national guidance was displayed on noticeboards within the ward areas. For example, on ward 15 there was a diabetes focus board with evidence based information for staff.

The trust reported that all new NICE guidelines were identified at the end of each month and were sent to clinical leads for each specialty for implementation.

Staff told us that all policies and procedures for surgery were being reviewed and where possible aligned with the Queen Elizabeth hospital to achieve consistency across the trust, following the acquisition. The senior management team told us specialties were taking steps towards integration and the review of pathways and procedures formed part of this.

The trust provided evidence that they completed audits to compare the care and treatment provided in each of the surgical specialties and whether this complied with NICE guidance for the procedures or other published data. For example, trauma and orthopaedics compared their results for hip resurfacing against published data and monitored the national joint registry results. They found their results compared favourably to other published studies and the national joint registry. Urology also looked at their use of botox in the treatment of overactive bladder in relation to the updated 2013 NICE guideline (CG171).

There was a programme of audit for each surgical specialty and the trust provided us with a sample of the audits completed and learning gained from them. As most of the surgeons at Solihull hospital, also worked at Heartlands hospital and/or Good Hope hospital, the results were sometimes specific to one hospital, when surgery was focused on one of the sites, and in other cases amalgamated results from more than one site. However, it was apparent from the data provided, that each specialty audited and assessed their practice on an ongoing basis. Examples of local audits included an audit of day case ambulatory care in vascular surgery, which led to an improvement in the quality of discharge letters following the audit and interventions and an audit of the ‘stop before you block’ initiative in regional anaesthesia.

Each specialty had a forward plan for audits for 2018/19, which included local and national audits, including assessment of compliance with NICE guidelines and trust policy.

Surgical services used some care pathways to ensure a consistent approach to the care and treatment of patients undergoing specific procedures. In addition, there was a day surgery care pathway and an inpatient surgical care pathway for routine procedures.

We observed staff in the pre-assessment clinic had access to standard operating procedures for a range of procedures including, day procedure unit admissions, gynaecological procedures, the enhanced recovery programme and anaemia. This ensured all the correct investigations and preparation was undertaken prior to surgery.

Staff used recognised tools where possible in the assessment of patients. These included occupational therapists use of the Manchester mobility score to measure patient improvement, and nursing use of risk scores for nutrition, falls and pressure ulcers.

Safety guidelines produced by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) were laminated and attached to the side of anaesthetic machines in the operating theatres. There were also emergency guidelines published by the Difficult Airway Society laminated in theatres.

However, there was little evidence of any audits in theatres to assess practice against the national standards for safe per-operative practice. Observational audits to assess compliance with the
WHO checklist were only just being initiated and had not been undertaken in the main theatres at Solihull hospital.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Patients had access to specialist advice and nutritional support as required. However, patient feedback about the quality of the food and choice was variable and they told us this affected the amount they ate.

Staff measured each patient’s nutritional status on admission to hospital using a national screening tool and a nutritional care plan was put into place, based on the results of this. When patients had special dietary requirements, this was identified on the handover sheet, but was not always identified in the patient’s nutritional care plan.

Ward housekeepers discussed food choices with patients approximately 30 minutes before the meal was served. However, the kitchens sent a fixed number of portions for each option on the menu and if more patients chose a particular option than the number supplied, they were asked to choose another option. Some patients told us this affected the amount they ate particularly when they had a poor appetite. One patient said, “They ask what you want, but if you say a salad for example, they might say they have all gone and you don’t fancy anything else, so you don’t eat as much.”

Ward food scored poorly at Solihull hospital as a whole in the patient led assessment of the ward environment audit (PLACE) in 2018. The Solihull hospital score was 86% for ward food as compared to a national average of 90%.

Patients had access to a dietitian when required and were provided with nutritional supplements when their nutritional intake was low.

Prior to surgery patients were kept ‘nil by mouth’ and fasted in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Patients who were admitted to hospital on the day of surgery and day surgery patients, were provided with clear instructions about the need to fast before their surgery and the time when they could have their last food and drink. When the order of the operating list was changed, the anaesthetist contacted the ward to let the staff know the patient could have additional drinks, where applicable.

Patients on the morning list were generally instructed not to eat after 2.30am or 3am and were told they could have clear fluids until 6am, whereas patients having their operation in the afternoon were able to have a light early breakfast. Patients told us they had been given written and verbal information about fasting times.

Pain relief

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

Patients care records showed that staff monitored patient’s pain and asked them about pain with every set of vital sign observations. The patient’s pain score was included in the vital signs observation chart alongside the MEWS. A visual tool with a series of sad and happy faces was printed in every patient’s nursing assessment booklet to use when a patient was unable to verbalise the level of their pain.

Patients told us staff responded quickly when they had pain and ensured pain relief was given promptly. One patient said, “My pain has been managed very well -100%. They give me pain relief quickly.” They went onto say that staff used a pain score and checked their pain again after they
had given the medicines. Another patient said, “Staff have been fantastic; they keep on top of my pain and I get pain relief quickly when I ask.”

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Performance in national outcome audits was mostly positive with good outcomes in the national vascular registry, the national bowel cancer audits and the national joint registry.

Relative risk of readmission

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Solihull Hospital – elective admissions

From May 2017 to April 2018, patients at Solihull Hospital had a higher than expected risk of readmission for elective surgical admissions compared to the England average.

Patients in ophthalmology, trauma and orthopaedics and urology had higher than expected risks of readmission for elective admissions.

Elective Admissions - Solihull Hospital

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Solihull Hospital - non-elective admissions

From May 2017 to April 2018, patients at Solihull Hospital had a higher than expected risk of readmission for non-elective surgical admissions compared to the England average.

Patients in trauma and orthopaedics had a higher than expected risk of readmission for non-elective admissions.

Please note: There were readmissions for breast surgery and urology which were included in the total figures but not in the specialty breakdown due to the small numbers involved.

Non-Elective Admissions - Solihull Hospital
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top specialty for specific site based on count of activity.

(Source: Hospital Episode Statistics)

National Hip Fracture Database

Data was not available for Solihull hospital as patients undergoing surgery for fractured hips were initially treated at other hospitals within the trust. The majority of orthopaedic surgery undertaken at Solihull hospital was planned or elective surgery.

Data from the National Joint Registry indicated that Solihull performed well in relation to other hospitals in terms of the standardised revision rate for hip and knee replacements and the standardised mortality rate. They achieved a green rating for all these indicators in 2017.

Bowel Cancer Audit

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 Bowel Cancer Audit, 68.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2016 figure was 69.8%

The risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The 2016 figure was 2.3%.

The risk-adjusted 2-year post-operative mortality rate was 21.9% which was within the expected range. The 2016 figure was 21.1%.

The risk-adjusted 30-day unplanned readmission rate was 11.3% which was within the expected range. The 2016 figure was 11.0%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 44.4% which was within the expected range. The 2016 figure was 44.4%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

Heart of England NHS Foundation Trust
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.7% for Abdominal Aortic Aneurysms. This was within the expected range. The 2016 figure was 0.8%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 12 days, which was better than the audit aspirational standard of 14 days. The 2016 figure was also 12 days.

The 30-day risk-adjusted mortality and stroke rate was 3.7%, which was within the expected range. The 2016 figure was 2.9%.

(Source: National Vascular Registry)

National Oesophago-Gastric Cancer National Audit

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the 2017 National Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.0%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation.

The 90-day post-operative mortality rate was 4.0%. This was within the expected range. The 2016 rate was 6.1%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.7%. This was similar to the national aggregate. The 2016 figure was 33.7%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

Patient Reported Outcome Measures

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17 performance on groin hernias was similar to the England average for the EQ VAS indicator but better for the EQ-5D Index.

For varicose veins, performance was better than the England average for both the EQ VAS and EQ-5D Index. Performance was similar for the Aberdeen Varicose Vein Questionnaire.

For hip replacements, performance was worse than the England average for the EQ VAS and similar to the England averages for EQ-5D and Oxford Hip Score.

For knee replacements was about the same as the England average for all three indicators.

(Source: NHS Digital)

The performance in the PROMs for hip and knee replacements may have been affected by a low patient participation rate. A senior clinician explained that an external organisation was not employed by the trust to follow up patients and encourage participation, thus increasing participation rates. Although Solihull hospital was mainly utilised for elective orthopaedic surgery, other hospital in the former Heart of England NHS trust cared for elective and trauma patients on the same ward. This has been shown to affect infection rates and outcomes.

Surgical services participated in the national radical prostatectomy outcomes project. Median post-operative stay was three days as compared to three days nationally for open surgery and was in line with national data for laparoscopic surgery.

Staff completed a study to investigate and improve surgical site infection following abdominal surgery. They completed a before and after study to determine the impact of additional measures to prevent surgical site infections. An evidence-based bundle of care comprising pre-operative, intra-operative, and post-operative measures was implemented. The study identified that SSI remained a major burden to patients after abdominal surgery. Introduction of the bundle significantly improved compliance with appropriate antimicrobial prophylaxis and significantly fewer patients required unplanned readmission; the observed rate of incisional SSI was reduced from 29.3% to 21.7% following implementation of the bundle of care.
The Summary Hospital-level Mortality Indicator (SHMI) performance for Birmingham Heartlands hospital, Good Hope hospital and Solihull hospital for the period April 2017 to December 2017 was 92 the expected level is 100. There were 3,281 deaths compared with 3,554 expected. HGS’s HSMR for the period April 2017 to March 2018 was 102 which is within acceptable limits. There were 2,816 deaths compared with 2,755 expected. The Summary Hospital-level Mortality Indicator (SHMI) is a score that reports on mortality rates at trust-level across the NHS in England.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance to provide support and monitor the effectiveness of the service.

Appraisal rates

From April 2017 to March 2018, 90.1% of staff within surgery at Solihull Hospital received an appraisal compared to a target of 85%.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>90</td>
<td>93</td>
<td>96.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>57</td>
<td>71</td>
<td>80.3%</td>
</tr>
</tbody>
</table>

This is the only site at which qualified nursing and health visiting staff failed to meet the target completion rate.

When we spoke with senior ward sisters on each ward they showed us evidence that their appraisals rates at the time of the inspection were over 90%. They all had a list of those staff whose appraisal was due that month to ensure they were completed in a timely way. All the staff we spoke with during the inspection, told us they had received an appraisal within the last 12 months. They said they had the opportunity to discuss their performance and their training and development needs. This indicated there had been an improvement since the figures above in March 2018.

Newly qualified nurses told us they received support and worked through a range of competencies to undertake their role. They said they were able to ask for additional training if they felt they would benefit from it. An occupational therapist also told us they had a competency framework which their manager signed off as they achieved the required competencies. A newly qualified operating department practitioner told us all the staff were happy to help and support them. They were working through a competency assessment in a structured way, initially working in recovery, followed by theatres and the scrub role and then anaesthetics. They said they had a meeting with the theatre manager and agreed their objectives for the first three months. Health care assistants also spoke of receiving opportunities to undertake further training and develop their skills.

Each ward had a range of champions or link nurses who had undertaken additional training in their link role, to enable them to provide advice to other staff on the ward. They also provided practice based training or updates where appropriate. We saw there were link nurses for diabetes, safeguarding, tissue viability, medical devices for example.
We observed staff providing care to patients competently and confidently. Patients told us they had complete confidence in the skills of staff and their knowledge. One patient said, “I have complete confidence in the staff and trust them 100%.”

We spoke with two student nurses who gave us very positive feedback about their placement on surgical wards and the support they received. They told us they were offered the opportunity to further develop their skills and competencies and were given the time to learn. They were allocated a mentor and had the opportunity to work with their mentor and to meet with them to discuss their progress. One of these said their meetings with their mentor had been invaluable as they had looked at their past feedback and allowed them to work on their weaknesses. They had found the experience very supportive and said that as a result their confidence had increased.

Most of the recovery staff had not undertaken advanced life support training, however a supernumerary anaesthetist was available which mitigated the risk to patients.

Medical trainees were able to attend regular teaching and had an allocated supervisor. The division had previously identified some imbalance between the opportunities for teaching and development for the non-trainee junior doctors and had worked to overcome this.

**Multidisciplinary working**

Multidisciplinary team working was effective. Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide coordinated care. We observed therapies staff were based on some wards and staff communicated well with each other.

We observed a range of examples of good multi-disciplinary working. We saw physiotherapy and occupational therapy on the surgical wards and saw staff of all disciplines working constructively with each other and listening to everyone’s views. A specialist physiotherapist was attending a ward to support a patient and they told us they received a good level of information about the patient on referral and we saw they were clearly documenting in the patient’s notes their interventions and the results of their assessment. A patient commented, “The physiotherapists etc. are all part of the team. Overall, I can’t fault any of them.” Physiotherapy support was provided on the day procedures unit to aid orthopaedic discharges. Staff told us they could refer patients to the dietitian or the speech and language therapy team when necessary and the patients would be seen promptly.

A housekeeping assistant told us they felt part of the ward team and said everyone worked well together; we observed this was the case during the inspection.

A weekly breast cancer multi-disciplinary team meeting was held weekly and we attended a meeting during the inspection. The meeting was jointly chaired by the lead consultant and clinical nurse specialist. We observed good attendance at the meeting with attendance by representatives from oncology, radiology, histology, nurses and surgeons. We observed input from all disciplines and each patient’s treatment options were considered. There was discussion about a patient’s right to refuse treatment alongside impact of surgery and patient expectations.

An ortho-geriatrician provided input to the surgical wards three times a week on the Solihull hospital site. They supported complex patients and discharges and provided advice to staff within the service of all disciplines.

**Seven-day services**

The service was working towards seven-day services. Surgical consultants were available on site seven days a week and physiotherapy and occupational therapy operated a seven-
day service. Ward 14 was open six days a week, however, plans were being progressed to move towards a seven-day service. Pre-assessment clinic and the day procedures unit were operational during defined hours.

Patients told us they saw a doctor every day, although this was not always a consultant.

Ward 14 was a short stay surgical and day case ward and was open from Monday at 7am to Saturday at 3pm. However, the senior management team were putting proposals forward to move to a seven-day service. At the time of the inspection, any patients requiring a stay which included Sunday, were moved to ward 15 or to Heartlands hospital on a Saturday afternoon. This was disruptive for patients and reduced their experience.

The day procedures unit was open Monday to Saturday 8am to 7pm. Patients not ready for discharge at 7pm were moved to ward 14 or ward 15. Two operating lists were scheduled in each of the two theatres from Monday to Friday. There was also a Saturday theatre list for urology or general surgery.

The operating theatres were staffed Monday to Friday with on-call teams available overnight and at weekends.

The main pharmacy department opening times were 9am - 5pm Monday to Friday, 9am - 1pm on Saturday and Bank Holidays and 10am - 1pm on Sundays (with additional cover by Heartlands hospital pharmacy outside of these hours until 4:00pm). There was an on call outside these hours which was available via switchboard. A Pharmacy electronic prescribing helpline was available 24 hours a day seven days week for the trust. (PIR)

There was good access to diagnostic and interventional radiology within the trust throughout the week and at weekends. Medical staff did not express any concerns about access to these services for their patients.

**Health promotion**

The service provided a range of information leaflets for patients in a range of formats. These included locally produced leaflets and leaflets provided by national organisations and charities.

Leaflet stands for healthy eating, stroke and smoking/alcohol cessation, were visible throughout the surgical wards. Cancer support information was also available. The British Heart Foundation and Macmillan had their own stands near the main entrance. We also saw a nutritional display board on a surgical ward with patient information about healthy eating, and diabetes.

The breast surgery team told us they held a health and well-being session that patients attended as their final appointment following breast cancer treatment to discuss diet, exercise, limb swelling and other relevant health topics.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff gained consent from patients to provide their care and treatment. Staff understood their responsibilities under the Mental Capacity Act (2005) and followed the trust’s policies and procedures when patients were not able to give their consent.

The trust had a consent policy based on national guidelines and recommended national consent forms were used. However, the policy was overdue for review, the review date being March 2018. The trust told us policies and procedures were being updated following the acquisition.

The procedure, along with its potential risks and benefits were discussed at the outpatient visit and explained again on the day of admission. Most patients signed their consent form on the day of admission. This is not in line with current best practice guidance which states that consent
should be gained prior to admission and re-visited on the day of surgery.

Patients we spoke with told us their treatment was discussed fully with them and the risks and benefits fully explained. They felt able to ask questions. They said that by the time they signed their consent form they felt fully informed.

We checked five consent forms and found they were fully completed and signed by the patient and doctor carrying out the procedure.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. Nursing and medical staff were able to explain when mental capacity assessments needed to be completed and that decisions were made in the person’s best interests. Staff told us they assessed each patient’s capacity to make a decision about their surgery and consent form 4 which includes assessment of capacity and best interest decision was utilised when applicable.

Staff were also aware of the Deprivation of Liberty Safeguards (DoLS) which protect patients who are unable to make decision when they are in hospital and care homes. They identified that there were some occasions when a DoLS authorisation was necessary and told us there was a flow chart to follow to ensure the correct applications were made.

**Mental Capacity Act and Deprivation of Liberty training completion**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Currently the trust has only been able to provide data for the Queen Elizabeth Hospital site. Information for the other sites has been requested and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

The trust combines safeguarding level 2, mental capacity and deprivation of liberty (DOLs) training.

**Queen Elizabeth Hospital**

A breakdown of compliance for mental capacity and DOLs training courses from April 2017 to March 2018 for qualified nursing staff in surgery at Queen Elizabeth Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding level 2/ DOLs and mental capacity</td>
<td>545</td>
<td>579</td>
<td>94.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The trust’s 90% completion target was met this training module.

A breakdown of compliance for mental capacity and DOLs training courses from April 2017 to March 2018 for medical staff in surgery at Queen Elizabeth Hospital is shown below:
Number of staff trained | Number of eligible staff | Completion rate | Trust target | Met (Yes/No)
---|---|---|---|---
Safeguarding level 2/ DOLs and mental capacity | 149 | 218 | 68.3% | 90.0% | No

The trust’s 90% completion target was not met for this training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff maintained patients’ privacy and dignity and showed concern about their welfare.

All the patients we spoke with, praised staff for their compassion and kindness. For example, one patient said, “Staff are first class; there are no weak links. They are always kind and come as quickly as they can.” Another patient said, “The nurses are wonderful; laughter is the best medicine and they are very good at lifting your spirits.”

Patients commented that nurses introduced themselves and they appreciated the fact that staff referred to them by name. We also overheard an anaesthetist introducing themselves to the patient and speaking with them sensitively, as they explained what to expect. In the operating theatres we observed an anaesthetist giving a full explanation to a patient prior to any intervention and maintaining their dignity by ensuring they were covered with a sheet.

Staff explained ways they maintained patient’s privacy and dignity by drawing the curtains around the bed, speaking with them quietly where possible and keeping people covered as much as they could when providing personal care. They told us they could take patients to the office to speak with them if they needed some privacy.

We observed staff checking patients were alright and speaking with them in such a way as to reduce their anxiety. A patient commented on the attentiveness of staff and their concern for every patient’s well-being.

**Friends and Family test performance**

**Solihull Hospital**

The Friends and Family Test response rate for medicine at the Solihull Hospital was 24.5%. A breakdown by ward is below (please note, only wards with at least 100 responses are shown).

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total responses</th>
<th>Response rate</th>
<th>Percentage recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Apr-18</td>
</tr>
<tr>
<td>Day cases</td>
<td>997</td>
<td>22%</td>
<td>93%</td>
</tr>
<tr>
<td>Ward 14</td>
<td>148</td>
<td>47%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 19</td>
<td>110</td>
<td>39%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)
Emotional support

Staff provided emotional support to patients to minimise their distress. Patients had access to specialist nurses and a multi-faith chaplaincy service.

Patients told us they received emotional support from nurses and other health professionals during their admission. One patient said, “The nurses pick you up from the bottom when you are low and they are there for you. I was supposed to be going home today, but now it is going to be Friday; though I am still in good spirits because of them.”

The breast care specialist nurse saw patients prior to their admission for surgery and supported them through their journey. They were with the patient when they received their diagnosis and when discussing treatments. Patients were allocated a key worker to look after their welfare throughout each stage. The service had strong links with a local charity which supports women through their breast cancer treatment and could provide counselling for patients and their families. Other specialist nurses provided similar levels of support to patients.

A chaplaincy service was available offering a service to people of different faiths. The chaplaincy department also had a group of volunteers who carried out bedside visiting.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Patients were aware of plans for their care and treatment and said they had been provided with the information they needed to help them make decisions about their care.

Patients we spoke with, said they felt able to ask questions and said they felt fully involved. They said staff gave them all the information they needed before they came into hospital and they knew about the overall plan for their care. One patient said, “The doctors explain everything. I have absolute faith in the doctors here. Another patient said that everything was explained and they were invited to ask questions. Patients generally knew how long they were expecting to stay in hospital and the plan for their discharge.

Patients told us they were provided with some written information to supplement and remind them of the verbal information given. They felt this increased their understanding and gave them confidence during their stay as they could remind themselves of the key steps through from admission to discharge.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Following the acquisition, the service was moving towards integration of surgical services whilst considering local needs.

The senior leadership team were in the process of reviewing the provision of surgical services across the trust following the acquisition. They were considering the most appropriate configuration in terms of specialty surgical provision, that might be concentrated on one site, whilst maintaining local delivery of core surgical services to meet patient need. They were working with the local commissioners and other stakeholders in this process.

The trust was moving towards a provider alliance with a neighbouring trust specialising in orthopaedic surgery, to improve orthopaedic referral to treatment times. They were working with this provider to develop a winter plan for the forthcoming winter period.
The service were working collaboratively with the local commissioners and other service providers to deliver an ophthalmology transformation plan, to improve ophthalmic care, reduce gaps in service provision and provide equality of access and treatment across the Birmingham and Solihull areas.

Surgical services were provided in an environment which, on the whole, was suitable for their needs. Wards were divided into single sex bays and there were a small number of side rooms that were mainly used for patients with infections. Bathrooms and toilets were designated as single sex, and the service was compliant with Department of Health guidance on single sex accommodation.

**Average length of stay**

**University Hospitals Birmingham NHS Foundation Trust**

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

**Solihull Hospital**

From March 2017 to February 2018 the average length of stay for surgical elective patients at Solihull Hospital was 3.7 days, which was similar to the England average of 3.9 days.

Average lengths of stay for elective specialties:

- Average lengths of stay for elective patients in urology and breast surgery were shorter than the England averages.
- Average length of stay for elective patients in trauma and orthopaedics was longer than the England average.

**Elective Average Length of Stay - Solihull Hospital**

![Bar chart showing average lengths of stay for Solihull Hospital and England average.]

*Note: Top three specialties for specific site based on count of activity.*

Over the same period, for surgical non-elective patients, the average length of stay was 3.4 days, which was shorter than the England average of 4.9 days.
Average lengths of stay for non-elective specialties:

- Average lengths of stay for non-elective patients in trauma and orthopaedics was shorter than the England averages.

- No other specialty had more than nine admissions over these 12 months.

**Non-Elective Average Length of Stay - Solihull Hospital**

![Bar chart showing average lengths of stay](chart.png)

Note: Top specialty for specific site based on count of activity.

(Source: Hospital Episode Statistics)

A member of the senior leadership team told us average length of stay for patients undergoing knee replacement had reduced from six to five days over the last two years, although length of stay for patients undergoing hip replacement had remained static. They felt that increased physiotherapy support as part of the enhanced recovery programme, would bring further benefits in terms of length of stay and patient outcomes.

**Meeting people’s individual needs**

The service took account of most patients’ individual needs. However, there was limited access to a face to face interpreter and important information was sometimes communicated by telephone. Staff awareness of the adjustments that could be made for patients with complex needs was sometimes limited.

The trust told us in their information return that it provided comprehensive face to face, telephone interpreting services and written translation services. The services were provided through an external supplier and a small team of in-house interpreting services. The service was provided in all languages including British Sign Language and is available 24 hours a day, 365 days of the year. The in-house interpreting team acted as a hub for all interpreting and written translation booking requests and was based at Heartlands hospital.

At Solihull hospital, staff told us they had access to an on-site interpreter employed by the trust who spoke three different languages and they provided face to face interpreting. However, in other circumstances they used the telephone translation service. Staff taking consent for surgery therefore used the telephone service. This is not considered best practice.

Staff in the pre-assessment clinic told us that when a patient attended with a learning disability or dementia, they asked the patient and their carer what they could do to facilitate and improve the experience for the patient. They told us patients were not normally kept waiting and were seen on time, therefore there was no need for them to make special arrangements for a patient who might
find waiting difficult. They did not identify that those people may require a longer appointment and that other adjustments might be needed to meet the patient’s needs. The waiting area in the pre-assessment clinic was small and there was limited consultation space which could be allocated for a patient if they needed a quiet space. Staff on the wards said the ward could accommodate a carer to stay with a patient with a learning disability or dementia. Prior to admission for surgery, the staff in the pre-assessment clinic flagged to the anaesthetist, surgeon and ward that a patient had a learning disability, to enable this to be considered when planning the operating list.

Staff told us there was a dementia nurse specialist who could be contacted for advice if necessary and staff had received training in dementia. The trust reported there was no process in place to notify the specialist nurses of admissions, however the team took referrals for assistance and the assessment of complex patients with dementia.

Staff in the day procedures unit told us they did not have any bariatric trolleys so could not admit bariatric patients. On the surgical wards, staff said they would need to obtain bariatric equipment from another hospital in the trust in order to admit a bariatric patient. The senior management team said they were exploring the possibility of extending the bariatric surgical service to Solihull hospital and therefore the requirement for specialist equipment would be considered.

Nurses assessed patients care and support needs when they were admitted using standardised documents. Staff completed the assessments to identify patient’s individual needs, although care plans for patients with specific needs such as dementia or confusion, to provide information for staff on how this affected the patient, were not completed. Staff told us this information was provided at handover.

Patients were provided with written information prior to their surgical admission. This included information provided at the pre-assessment clinic such as, information about preventing deep vein thrombosis, their anaesthetic, fasting instruction, day case procedure information and discharge information.

Access and flow

Patients could access the service when they needed it. Waiting times from referral to treatment were approximately the same as the national average. The service had a plan in place for each specialty to improve referral to treatment times. However, cancellation rates for elective operations in the trust as a whole, for the first quarter of 2018/19 were above the national average.

Referral to treatment (percentage within 18 weeks) - admitted performance

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

From August 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was above the England average, however this decreased to a similar level to the England average from April to July 2018.
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was about the same as the England average.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement. Data submitted in April and May under the code for Heart of England NHS Foundation Trust was included in this analysis as it was after the date of acquisition.

Six specialties were above the England average for RTT rates (percentage within 18 weeks) for
admitted pathways within surgery for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>96.8%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>91.0%</td>
<td>60.4%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>90.4%</td>
<td>81.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>83.6%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat</td>
<td>75.0%</td>
<td>62.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>72.7%</td>
<td>68.5%</td>
</tr>
</tbody>
</table>

Three specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to July 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>60.9%</td>
<td>70.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>58.6%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>57.4%</td>
<td>60.2%</td>
</tr>
</tbody>
</table>

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Five specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>98.2%</td>
<td>80.8%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>94.4%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>85.6%</td>
<td>77.4%</td>
</tr>
<tr>
<td>General surgery</td>
<td>75.4%</td>
<td>73.5%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat</td>
<td>74.9%</td>
<td>63.2%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery for August 2017 to March 2018.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>57.8%</td>
<td>69.6%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>43.4%</td>
<td>61.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The senior leadership team told us there had been a concerted effort to improve referral to treatment times. There were ongoing challenges in trauma and orthopaedics due to bed and theatre capacity and arrangements had been made with the private sector and a neighbouring NHS hospital to undertake some orthopaedic surgery. As a result of these actions and actions
within the trust, the situation had improved over the summer and at the end of August 2018, the referral to treatment time had improved to 79%.

The trust had an overall action plan for referral to treatment times. Actions included ensuring maximum use of theatre capacity, including scheduling additional lists. There was an action plan in place for each specialty to address referral to treatment times and weekly meetings to them, along with confirm and challenge meetings. All patients waiting over 40 weeks were reported and escalated and harm reviews were completed.

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Over the two years, this trust cancelled 3,440 surgeries. Of the 3,440 cancellations, the trust had a lower rate of patients not seen within 28 days than the England average for all quarters apart from July to September 2016 and October to December 2017.

Percentage of patients whose operation was cancelled and were not treated within 28 days - University Hospitals Birmingham NHS Foundation Trust

[Graph showing the percentage of patients whose operation was cancelled and were not treated within 28 days]

Cancelled Operations as a percentage of elective admissions - University Hospitals Birmingham NHS Foundation Trust
Over the two years, the percentage of cancelled operations at the trust showed was consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From July 2016 to March 2018, this trust cancelled 2,326 surgeries. Of the 2,326 cancellations, the trust reported that 0% weren’t treated within 28 days. This was consistently lower than the England average.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Heart of England NHS Foundation Trust**

Cancelled Operations as a percentage of elective admissions - Heart of England NHS Foundation Trust
From July 2016 to March 2018, the percentage of cancelled operations at the trust showed a rate consistently higher than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Medical staff told us that the number of cancelled operations at Solihull hospital tended to be lower than in the other hospitals in the trust as only elective surgery was carried out at Solihull hospital. However, there was some impact from medical outliers and transfers of patients from other hospitals within the trust. We spoke with two patients who were initially booked for surgery at one of the other hospitals in the trust and whose surgery was moved to Solihull hospital due to a lack of capacity at the other hospital. Following the inspection, the trust provided data that showed 108 theatre sessions were cancelled from October 2017 to September 2018 at Solihull hospital.

We observed a morning theatre briefing session prior to the start of the operating session, where patients on the operating list for that day were discussed with the equipment requirements, anaesthetic requirements and risk and co-morbidities. From this the order of the list was confirmed. This ensured that patients individual needs were identified and patient flow was considered.

When patients were ready for discharge, nursing staff told us there were some challenges in obtaining the patient’s discharge summary in a timely manner and in obtaining medicines patients needed to take home with them (TTOs). However, wards kept a stock of those medicines that were normally prescribed for patients to take home following surgery and this meant the ward was not reliant on the pharmacy to provide medicines, for most patients. Staff said patients were not normally discharged without the discharge summary being completed and they were able to provide a copy for the patient to take home with them.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. The number of complaints received for surgical services at Solihull hospital was low. However, complaints were not always closed within the 30 working day timeframe stipulated in the trust complaints policy.

The trust had a complaints policy and a complaints and Patient Advice and Liaison Service (PALS) team. We saw some information about these was available in the clinical areas.

Summary of complaints
**Trust level**

From April 2017 to March 2018 there were 188 complaints about surgery across the trust as a whole. The trust took an average of 38.8 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 30 working days.

Of the ten complaints still open at the time of reporting, all had been open longer than the trust’s target of 30 working days, with the longest being open for 252 working days.

A breakdown by site is below:

- **Queen Elizabeth Hospital**: There were 118 complaints, the main themes were clinical treatment with 35 complaints (29.7%), patient care including nutrition / hydration with 25 complaints (21.2%), staff with 16 complaints (13.6%), admissions, discharges and transfers with 15 complaints (12.7%) and communications with 15 complaints (12.7%).

- **Birmingham Heartlands Hospital**: There were 39 complaints, the main themes were all aspects of clinical treatment with 25 complaints (64.1%) and admissions, discharge and transfer arrangements with six complaints (15.4%)

- **Good Hope Hospital**: There were 20 complaints, the main theme was all aspects of clinical treatment with 11 complaints (55.0%).

- **Solihull Hospital**: There were 11 complaints, the main themes were all aspects of clinical treatment with three complaints (27.3%), appointments, delay/cancellation (in-patient) with three complaints (27.3%) and communication/information to patients (written and oral) with two complaints (18.2%).

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

**Number of compliments made to the trust**

From April 2017 to March 2018 there were 627 compliments within medicine.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth Hospital</td>
<td>490</td>
<td>78.1%</td>
</tr>
<tr>
<td>Nuffield House</td>
<td>119</td>
<td>19.0%</td>
</tr>
<tr>
<td>Birmingham Heartlands Hospital</td>
<td>12</td>
<td>1.9%</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>627</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

Patients we spoke with knew how to make a complaint and told us they had been provided with information about this. Patients told us that if they had a complaint or a concern they would speak with the senior sister in the first instance.
Senior sisters were aware of the complaints they had received and were able to describe the taken to address the complaint. In addition, we were told that patients sometimes complained if they had to be moved to another ward if they were not ready to go home when the day procedures unit closed or a ward closed at the weekend. Staff told us they did their best to explain the reasons to patients.

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, staff above band seven were mainly based on other hospital sites and this sometimes impacted on their visibility and support.

The senior leadership and management team for surgical services at Solihull hospital also managed surgical services at Birmingham Heartlands hospital and Good Hope hospital. Most surgical specialties were within division 5; however, theatres, anaesthetics, day case and ambulatory surgery were managed separately within the clinical support services division (Division 1). Each team was led by a divisional director, director of operations, finance manager and head of nursing. The head of nursing was supported by matrons who had responsibility for specific specialties and also covered more than one hospital site.

We spoke with the divisional directors and head of nursing for division 5, and other members of the corporate management team. We found they had a good grasp of the issues and challenges facing the service and were working together to take forward improvements. However, the fact that theatres, anaesthetics and day surgery were managed in different divisions meant there were separate lines of responsibility and there was not always someone with the overall picture. We did not see examples for joint meetings between theatres and wards, that we have seen in other trusts. However, there were collaborative relationships between the wards and theatres and day surgery and no evidence of specific difficulties.

Senior sisters told us the matrons were supportive and always available on the telephone. However, the amount of time the matrons spent on site and therefore in the clinical areas was variable. Band seven staff told us the matrons usually visited the wards or theatres one day a week and other staff commented they saw their matron about twice a month. This limited the matron’s ability to oversee care on their wards on a day to day basis, although the matrons themselves told us they felt they had a good understanding of the day to day issues. One matron covered staffing across the division on a daily basis. The matron for theatres also covered theatres across their division and therefore also visited the Solihull theatres one day a week. From our discussions with staff, we felt that less experienced managers would have benefited from increased development, guidance and support.

Divisional band seven meetings were held which the senior sisters attended and found helpful. The meetings provided the opportunity to discuss practice and share learning across the three hospital sites. A senior sister gave us an example of observational charts that were used at Heartlands hospital initially and had been introduced at Solihull hospital. Meetings with staff from the Queen Elizabeth hospital were in their infancy.

Senior ward sisters were aware of their ward’s performance in relation to the quality metrics measured on a monthly basis, the percentage of staff who had completed mandatory training and their appraisal rates. They showed good leadership skills and staff told us they were supportive, helpful and flexible.
The senior sisters held regular team or staff meetings and staff told us they were encouraged to discuss concerns, incidents, complaints and improvements to practice. Staff told us they were informed of changes and the results of audits at the meetings.

Senior sisters were given some supernumery shifts to carry out their managerial and supervisory role and on other days worked clinically. In theatres, there was no supernumery coordinator and the theatre manager acted as the coordinator and also worked clinically. This reduced the time available to act in a supervisory capacity and oversee the quality of care.

Vision and strategy

Staff were aware of the trust’s vision to, “Build healthier lives.”

The main focus going forward following the acquisition was the full integration of surgical services across the trust to create a single division for surgery. Progress was being made specialty by specialty and managers told us vascular, plastics, urology, breast and upper gastro-intestinal surgery were leading on this. Therefore, the strategy was based on further integration of services.

Although many of the policies and processes for the Birmingham Heartlands, Good Hope and Solihull sites were separate from those for the Queen Elizabeth Hospital, work was being undertaken to integrate these.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff told us there was a culture of openness and they felt confident to raise any concerns and challenge practice. One member of staff in theatres told us of a time when they had challenged another colleague’s practice. They said it was escalated and the person was provided with additional training to rectify the problem.

Staff we spoke with were overwhelmingly positive about working at the trust. A patient commented on the positivity of nursing staff and said that no matter how busy they were, they were upbeat and lifted their spirits. In addition, staff spoke about the good team working within their staff groups and with the other professionals they worked with on a day to day basis.

Most staff were aware of who the trust’s freedom to speak up guardian was. The role of the freedom to speak up guardian is to ensure that staff have the capability to speak up effectively and are supported appropriately.

Governance

The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. We found examples of discussion at specialty and divisional level to identify improvements to the quality, safety and effectiveness of care.

However, there was little engagement or understanding of governance issues below band seven level.

Surgical services had an established clinical governance framework at divisional and specialty levels. At divisional level there was a quality and safety committee that met monthly and directorates reported to this committee. We reviewed the minutes of a meeting and found there was good attendance from clinical directors, governance leads, matrons, and the senior management and leadership team for the division. There was a structured agenda with discussion of risks, incidents complaints and reports from each specialty governance group.
We reviewed the minutes of clinical governance meetings held at specialty level and whilst the agenda was not consistent across the different specialties, there was evidence of a discussion of incidents, risks, audits and ongoing operational challenges to the quality of the services. Each specialty had a nominated audit lead. There was good attendance at most meetings although we noted that in most cases junior doctors and ward sisters were not in attendance. We spoke with senior sisters and they told us they did not attend clinical governance meetings, however, the matrons cascaded information from governance meetings at their divisional band 7 meetings.

Theatres, anaesthetics and day surgery held audit days on a quarterly basis when electives surgery was suspended and a planned programme of presentations and discussions took place in relation to learning from clinical audits and incidents and training was provided.

Divisional band seven meetings were led by the divisional head nurse and these focused on quality improvement initiatives, learning from others and sharing good practice.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risks were clearly identified in the divisional risk registers.

Divisional risk registers identified the key risks within each division. We reviewed the risk registers and found the risks we had identified during the inspection were generally identified on the risk register. Minutes of the specialty governance meetings showed that risks for each specialty were identified and reviewed. Risks associated with junior medical staffing were identified in most specialties, however, actions to mitigate the risks were identified and we noted that in some specialties these issues had reduced. Nurse staffing was also identified as a risk on the risk register and actions were being taken to address these through an ongoing recruitment programme and the development of associate practitioners. Risks related to insufficient surgical bed capacity were identified in most specialties and had remained on the risk register for over two years. However, the senior leadership team told us they were looking at how they could maximise the use of the surgical beds at Solihull hospital where elective surgery was undertaken. The hospital was mainly utilised for short stay and day case surgery as there was limited access to high dependency care and out of hours medical cover.

Nursing quality metrics were measured and reported on a monthly basis. Matrons from another area completed the audits to ensure independence. The metrics covered a wide range of quality indicators including number of pressure ulcers and falls, VTE assessment, medicines management, patient safety and dignity, nutritional assessment, observations and manual handling. Ward 14 achieved an overall score of 98% in August 2018 and ward 15 scored 99% against a trust target of 95%. Both wards achieved an overall score of over 95% in every month from September 2017 to August 2018. Each indicator was rated using the red, amber, green traffic light system to identify at a glance those indicators that fell below the trust target.

Senior sisters told us their matron met with them to discuss the metrics, if they had any areas in which they scored a red rating for two consecutive months.

Root cause analysis (RCA) was completed for hospital acquired grade 3 and 4 pressure ulcers and injurious falls. Senior sisters told us they completed an investigation and a checklist on the electronic incident reporting system to identify whether all preventative measures were in place prior to the incident. They said the falls specialist nurse or the tissue viability nurse reviewed the investigation and together agreed whether it was avoidable.
The division showed evidence of a planned approach to clinical audit in that each specialty had an audit plan for 2018/19 and monitored progress against it.

**Information management**

The trust collected, analysed, managed and used information well to support its activities. Most records were paper based and when electronic systems were used, security safeguards were in place.

The service effectively used the information gained from data collection and audits to challenge and improve practice. We saw evidence of the escalation of issues to the quality and safety committee when required.

Medical records relating to each patient’s current admission in ward areas were paper based and stored in lockable trolleys on the wards. During the inspection we found that these trolleys were locked in accordance with requirements. Nursing daily records of care such as vital signs observations and food and fluid balance charts were stored at the end of each patient’s bed.

Wards had white boards identifying the names of patients in each bed although there was no other information about the patient such as their diagnosis.

Computers used on the wards to access patient information, such as results of investigations, discharge letters and medicines systems, were always logged out when we observed them unattended, thus protecting patient information.

In the pre-assessment clinic staff told us the availability of patients records when patients attended was good and they did not identify any issues. However, in the day procedures unit, staff told us they experienced challenges in relation to the location and availability of patient records, particularly when the patient attended for pre-operative assessment the day before surgery. Administrative staff told us it was necessary to request patient records more than once on occasions. They said they had a good rapport with the pre-operative clinic staff, however, there was lots of chasing of notes. They told us patients’ surgery was sometimes cancelled due the notes not being available although it only happened once every two to three months. In these instances, they completed a cancellation form.

Trust policies and clinical guidelines were available on the trust intranet. Some staff told us they found it easy to access policies and guidelines whilst others told us they had experienced difficulties in finding particular policies.

**Engagement**

The trust reported that in the 2017 national staff survey they scored within the bottom 20% of trust for staff recommending the trust for work and for treatment. These scores showed a small improvement as compared to the previous year. The number of staff receiving an appraisal was 90%, which is in the top 20% of trusts.

During the inspection we found staff showed an enthusiasm for their work and a commitment to providing a high quality of care. They told us communication at ward level was good and there was good team working. Staff found out about changes in the trust by regular emails and they saw senior managers very infrequently. The exception to this was the divisional head of nursing who they told us visited the wards and spoke to staff.

There were divisional band seven meetings that staff found useful to share practice and keep abreast of developments in the trust. However senior sisters told us the trust band seven meetings had not been held for some time. They said they had raised this with the director of nursing and they had suggested the senior sisters took the lead and coordinated the meetings.
Monthly staff meetings were held in the wards and theatres and staff said they were encouraged to contribute their views.

Staff on ward 14 were aware of the proposal to extend the hours of opening of the ward, although told us they felt communication could be improved. The senior leadership team explained that the proposal was still in its initial stages and the business case was still being developed, therefore they did not have any firm proposals and time scale at that time.

The trust had a patient and carer council, that were consulted on a number of trust wide initiatives. They were involved in a discussion about the new ambulatory care and diagnostics building at Heartlands hospital and were involved in the patient led assessments of the hospital environment.

We found a range of information available for patients and relatives about the friends and family test and feedback they had received. This also described actions taken to further improve and act on suggestions made.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Senior medical staff for trauma and orthopaedics said they had a plan to re-configure services over the next four years, to achieve separation of trauma and elective orthopaedic services. They told us one of the key issues were the lack of intensive care facilities at Solihull hospital.

The trust gave us examples of two areas in which they were providing innovative practice at Solihull hospital and Heartlands hospital. These were urolift surgery in patients with a benign enlarged prostate and the prostate clinical pathway.

Student nurses gave us very positive feedback on the quality of the learning environment on the wards and day procedures unit at Solihull hospital and the amount of support they received. This made them more likely to want to return to the hospital when they qualified. The senior sister on ward 15 and 16 said they had been nominated by student nurses for their teaching.

A high proportion of patients in surgery were treated as day cases, reducing the disruption to patient’s daily lives.

The division were exploring the possibility of extending the opening hours of ward 14 to provide more flexibility and increased surgical capacity.

The division had a process in place for learning from deaths. Morbidity and mortality review meetings were held for each specialty. Staff and managers told us there was a constructive learning atmosphere at the meetings. We reviewed the notes of a sample of mortality and morbidity meetings and saw there was a full discussion of each case and learning points were identified.
Maternity

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Maternity services have been provided by University Hospitals Birmingham NHS Foundation Trust from April 2018. Prior to this date they were provided by Heart of England NHS Foundation Trust.

The trust has 145 maternity beds across three sites:

**Good Hope Hospital**
- Delivery suite – 20 beds plus two pool rooms and a HD
- Ward 4 – 11 beds, mix of induction and inpatient
- Ward 5 – 22 postnatal beds

**Birmingham Heartlands Hospital**
- Aspen Ward – 19 beds plus seven transitional care beds
- Delivery suite – 23 beds plus six induction beds
- Cedar Ward – 19 postnatal beds
- Maple Ward – 26 postnatal beds
- Willow Ward – 3 postnatal beds
- Eden Ward – bereavement suits with two beds

**Solihull Hospital**
- Three birth rooms
- Two postnatal rooms

Queen Elizabeth Hospital does not provide any maternity services.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust provides consultant led, midwifery led stand alone and alongside units. In addition, there are teams of specialist and community midwives who care for women during their pregnancy and postnatal period.

The trust reported that their maternity services are working closely with local specialist trusts in the BUMP (Birmingham & Solihull United Maternity and Newborn Partnership project) looking at access, choice and continuity of care across the organisations.

(Source: Acute PIR – Context acute HGS tab)

Heart of England NHS Foundation Trust
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From April 2017 to March 2018 there were 9,348 births at the trust.

The Netherbrook birth unit had 142 births from April 2017 to March 2018.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

The Netherbrook birth unit offers a friendly low risk environment with an emphasis on midwifery led care, there are no obstetric medical facilities at the location. The birth unit accepts women who have been assessed as low risk in their pregnancy. If complications arise during the labour, birth or postnatal period women and/or their baby would be transferred as an emergency in an ambulance to the Good Hope Hospital maternity unit where high risk obstetric care is available.

There is a team of core midwives and maternity support workers (MSW) who staff the unit with one midwife and a MSW during the night and one midwife during the day. When a woman is admitted staffing is increased to two midwives, the second midwife is provided by the Solihull, Good Hope and Heartlands community midwives.

The trust has maternity services on three sites therefore there will be some similarities within the three reports.

Number of babies delivered at Heart of England NHS Foundation Trust – Comparison with other trusts in England

(Source: Hospital Episodes Statistics)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Heart of England NHS Foundation Trust by quarter
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service had a comprehensive training programme to provide staff with the training they required.

Mandatory training completion rate

Solihull Hospital

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified midwifery staff in maternity at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>37</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>37</td>
</tr>
<tr>
<td>Waste management</td>
<td>37</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>37</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>36</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
In maternity, the hospital had an overall training compliance rate of 95.9% for qualified midwifery staff. The trust’s 90% completion target was met for 10 of the 12 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The education midwife had responsibility for training and monitoring staff compliance. If training was cancelled due to staffing concerns, those staff were reallocated as a matter of priority. All staff we spoke with told us they were supported and up to date with their training.

Training was a three day programme which staff were expected to attend annually. This included the trust mandatory specific training, recognition of the deteriorating women, resuscitation of the newborn, obstetric skills, cardiotocograph (CTG) and drills of emergency scenarios and other sessions according to service needs identified from risk or incident themes. We requested the trust target for attendance at the obstetric skills training, we did not receive this information, which meant unable to be assured that the compliance rate for training had been met.

All staff attended PREVENT training (The Counter Terrorism and Security Act 2015 introduced the Prevent duty for various bodies to stop vulnerable people being exploited and drawn into terrorism). The Matron for the service arranged advanced training with the local police force to enable staff to feel more confident in their roles in the community.

Safeguarding

Staff were aware of processes and standard procedures to keep people safe from abuse. Staff received training to assess, recognise and report abuse.

Safeguarding training completion rates

Solihull Hospital

A breakdown of compliance for safeguarding training courses from April 2017 to March 2018 for qualified midwifery staff in maternity at Solihull Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding level 1 children and adults</td>
<td>37</td>
</tr>
</tbody>
</table>

In maternity, the hospital had an overall safeguarding training compliance rate of 100.0% for qualified midwifery staff. The trust’s 90% completion target was met for the only safeguarding training module.
Staff told us they completed safeguarding levels 1, 2 and 3 depending on their clinical role. Face to face training was provided for levels 2 and 3. Data obtained from staff during the inspection showed 88.1% of all staff had completed their required level of safeguarding training up to the end of September 2018. We were told 96% of midwives had completed level 3 safeguarding training.

Midwives told us they were able to raise concerns and knew how to report a safeguarding incident. Staff we spoke with told us that they received training on recognition of sexual exploitation and female genitalia mutilation (FGM) training, staff were aware of the processes to report cases identified and there was a FGM guideline to support staff and there was a named safeguarding midwife who provided support and supervision to staff. The service implemented the FGM Risk Indicator System (RIS) in May 2018 which is a system that flags children deemed to be at high risk of FGM.

The safeguarding midwife worked in partnership with the trust’s safeguarding team. All community midwives we spoke with said supervision was valuable and promoted learning and discussion about their caseloads.

Staff explained that they worked in partnership with external agencies to safeguard adults and children. The community midwives had good relationships with the general practitioners (GP’s) and health visiting teams.

Safety was promoted in the recruitment process for example all staff employed by the service had to have a completed Disclosure Barring Service (DBS) check (criminal record check) which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children.

Maternity hand-held paper records included a safeguarding risk assessment and we observed that there was a clear safeguarding flagging system to highlight a safeguarding concern to staff. This meant that the service had a process in place to support staff to identify women with safeguarding concerns.

The trust had a baby abduction policy and staff told us that the service used an electronic tag system for babies which meant that babies were not at risk of abduction.

**Cleanliness, infection control and hygiene**

There were reliable systems in place to ensure standards of cleanliness were met and protect people from a healthcare-associated infection.

All areas we visited were visibly clean tidy and uncluttered. There was a system throughout the service to identify what had been cleaned ‘I am clean stickers’ were routinely used. There was a room cleaning form in each birthing room to identify that the room was clean and ready to use.

Hand sanitising units and handwashing facilities were available throughout the unit and handwashing prompts were visible for staff, women and the public. The sanitising unit at the entrance was broken, it had been reported but there was no alternative for visitors to sanitise their hands on entry to the birthing unit until they were inside the unit.

Hand hygiene audits were provided for the trust overall performance which showed between April 2018 to September 2018 results were from 90.92% to 99.55% we were not provided with the trust target.

The curtains around the beds were disposable and all signed and dated. The curtains were changed on contamination or six-monthly rolling programme.
Waste disposal was managed appropriately with different types of foot controlled waste bins and different laundry bins to separate used laundry appropriately. Sharps boxes for the disposal of needles were assembled, not over full, signed and dated. Community midwives had smaller portable sharps boxes and disposed of waste according to the infection prevention control (IPC) policy.

Community midwives had the cleaning materials, hand sanitiser, personal protective wear required to ensure was adhered to.

We observed all staff were following the bare below the elbow initiative.

The number of MRSA or clostridium difficile cases reported in the maternity services was zero between April 2018 to September 2018. MRSA is a bacterium responsible for several difficult-to-treat infections and clostridium difficile is an infective bacterium that causes diarrhoea, and can make women very ill.

**Environment and equipment**

**The service had systems, processes and practices in place to manage the environment and equipment to keep people safe.**

The maternity led unit complied with the Department of Heath recommendations 2013, the three birthing rooms had ensuite facilities.

The manager of the birthing unit informed us that following the last inspection the process for evacuation from the pool in an emergency was with the evacuation net and staff were trained to use it. The pool was clean and maintained staff were aware of the cleaning regime.

Resuscitation equipment was checked and recorded daily. The neonatal resuscitaires were managed and checked daily with good compliance.

Equipment was checked in line with safety standards. We checked a sample of equipment such as baby scales, electronic blood pressure taking machines and thermometers. We reviewed 15 items of equipment, all had been checked by the medical engineering team. The community midwife’s equipment log demonstrated that all community midwives’ equipment had been checked and was in date.

Community staff we spoke with said they had all of the equipment needed to do their work. They all had normal size and large blood pressure cuffs which meant that observations taken could be accurately. There were enough carbon monoxide monitors to be able to check women’s levels antenatally.

The community staff carried the correct emergency equipment required to attend a baby born at home unplanned or a home birth. We observed equipment in the boot of a community midwife’s car and the check list sheets for all of the teams which meant they had the correct equipment ready to use.

The birthing unit had a closed-circuit camera television video (CCTV) to monitor entry and exit to the ward areas with an intercom buzzer system to enable staff to allow entry to the ward areas. This system ensured women and babies were safe and reduced the risk of baby abduction.

The trust provided community midwives with mobile phones which meant they could call for help in an emergency or if they needed to contact a colleague. Community midwives were recently provided with a safety device which could be triggered alerting emergency service assistance if required. Staff we spoke with were getting used to using them but felt safer for having them issued.

**Medicines**
The service followed best practice when prescribing, giving and documenting medicines.

Medicines were checked, managed, stored and disposed of safely, the service had pharmacy staff to support the areas. Controlled drugs (medicine that are controlled under the Misuse of Drugs legislation 2001), were checked by two members of qualified staff twice a day in line with the medicines policy and were stored correctly in a locked cupboard.

Midwives exemption medicines were accessible to staff which enabled midwives to give specific medicines without a woman seeing a doctor.

Fridges that contained medicines were locked and temperatures checked and recorded daily. The room temperature where the fridge was located was checked and recorded daily.

Midwives exemption medicine and patient group directions (PGDs) were clearly marked on prescription charts that we checked. PGDs and midwives exemptions allow some registered health professionals (such as nurses and midwives) to give specified medicines (such as painkillers) to a predetermined group of patients without them seeing a doctor.

We reviewed three prescription charts; personal information, the women’s weight and allergies were documented.

Community midwives did not routinely carry medicines, if attending a home birth, they would collect the medicines and nitrous oxide (gas and air for pain relief) gas cylinder from the birthing unit prior to attending the woman in her home. The gas cylinders were kept in a vented locked room. The medication required for the birth of the placenta is collected from the fridge on the birthing unit. The midwives used a poster to put in their car to inform other road users when they were carrying a gas cylinder.

Records

**Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

The service was paper light and used paper hand held records and electronic records. The electronic system was used antenatally and during birth. The service was working towards a united electronic system as part of the Birmingham & Solihull United Maternity and Newborn Partnership (BUMP). This meant in the future women’s electronic records could be accessed by all providers in the BUMP partnership, improving sharing of information.

We reviewed eight sets of maternity records; risk assessments, care plans and results were documented. Entries to the records were of a good standard, fully completed, legible, dated, timed and signed.

Community midwives were allocated IPads to document care, which were due to be replaced by laptops by the end of 2018. Results would be accessed at GP surgeries, within the birth centre or they could call the laboratory directly. The community midwives stored their encrypted electronic devices overnight in the homes not in their cars.

The medical records which were kept in the birthing unit were stored safely.

On discharge home, an electronic summary was immediately sent to the General Practitioner, the Health Visitor and a copy in the medical records to hand over care to the appropriate health professionals.

Women received the personal health record often called the ‘red book’ to keep details of their baby's development and take with them to all future baby appointments and reviews. Staff
completed the sections they were required to and women were aware of the use.

**Assessing and responding to patient risk**

**The service responded appropriately to changing risks to women who used the services.**

Women received risk assessments at their initial booking visit with the community midwife. This included a history of previous pregnancies, family history, social, medical and mental health assessments. At each antenatal appointment women’s individual risks were reviewed and reassessed. Women attended a place of birth antenatal assessment at 36 weeks of pregnancy, to determine if they could give birth at the birthing unit. Only women risk assessed as low risk were able to birth their baby at the birth unit or within their own home. Women with identified with high risks would be advised to birth their baby at the consultant led unit. Staff we spoke with explained that women who were low risk and planned for a home would be transferred into the consultant led unit if any risk factors became present. The community midwife would call 999 for an immediate transfer into the consultant led unit.

Staff were aware and followed process to record information relating to domestic abuse in line with the recommendations from the national inquiry into maternal deaths (MBBRACE-UK collaboration, December 2015).

We observed that midwives carried out venous thromboembolism (VTE) risk assessments to identify women potentially at risk. A VTE is a life-threatening condition where a blood clot forms in a vein. The service audited compliance with the trust’s VTE screening tool. From our review of the minutes of the Obstetrics and Gynaecology Quality and Safety meeting in October 2018, compliance was 98.42%.

Staff attended sepsis training annually and were able to describe the sepsis screening and could describe how to escalate concerns to medical staff and transfer women to the high risk maternity unit.

The birthing unit followed SBAR (situation, background, assessment, recommendation) format, a technique used to facilitate prompt and appropriate communication if they needed to transfer women to another unit. We did not have any records available to observe compliance at the time of our inspection.

Staff were aware of the birthing pool guidance and evacuation procedures, including manual handling guidance for care of the women. Each woman was risk assessed to use the pool prior to being included in the birthing plan. The staff practiced ‘skills and drills’ for the emergency removal of the women. Equipment was available to enable an evacuation to take place.

Midwives followed the trust policy for the transfer of women in labour to a consultant led unit including the management of women or babies who showed signs of deterioration and required additional care. Women were always transferred by ambulance from the birth unit to the consultant led unit, with a telephone call to the receiving unit. Staff told us that the process worked well and that they were well supported by the consultant unit in these situations. We requested the transfer out statistics from the previous year, we did not receive this information.

The maternity dashboard did not collate one to one care for women in labour statistics, staff we spoke with said all women on the MLU received one to one care, the national standard is 100%.

**Midwifery staffing**

Staffing levels were planned and reviewed to ensure women and babies received safe care and treatment.
Staffing levels were displayed on the unit. In the day there was a midwife rostered with support from the community. Out of hours there was a rostered midwife and MSW, with two community midwives on call at night to enable cover for home births, or be the second midwife in the birthing unit as required.

Core staff on the birthing unit were not called to help out at the consultant led unit in busy times, however, community midwives were. Community midwives we spoke with felt pressured at times when they were called out of hours, due to their workload the following day. The teams were supportive of one another and were flexible in covering each other’s areas.

The birthing unit did not use agency midwives, where there were staffing shortages, cover was arranged internally.

**Planned vs actual**

The trust has reported their staffing numbers below for March 2018 and June 2018 for qualified midwifery staff in maternity. The midwife to birth ratio for the maternity service was calculated as one to 27 women. Community midwives’ caseloads varied from 80 to over 100 women depending on the demographics and clinical need of women in their area. The teams were flexible and would provide assistance to one another to ensure women were provided with safe care and treatment.

The overall fill rate for qualified nursing staff dropped was around 95% for both time periods.

<table>
<thead>
<tr>
<th>Site</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE in month</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>32.8</td>
<td>32.4</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From April 2017 to March 2018, the trust reported a vacancy rate of 2.7% for nursing staff in maternity. This was lower than the trust target of 5% for nursing staff.

The breakdown by site was as follows:

- Birmingham Heartlands Hospital: 2.4%
- Good Hope Hospital: 3.4%
- Solihull Hospital: 2.7%

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From April 2017 to March 2018, the trust reported a turnover rate of 12.5% in maternity for qualified nursing and midwifery staff. This is above the trust target of 8.5% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:

- Birmingham Heartlands Hospital: 11.5%
- Good Hope Hospital: 14.3%
- Solihull Hospital: 14.3%
Staff we spoke with were concerned with the turnover rates for the birthing unit. They explained that many staff left when it was announced that the birthing unit was going to close. This plan had since changed to the unit being downsized to one birthing room and one postnatal room.

Sickness rates

From April 2017 and March 2018, the trust reported a sickness rate of 5.1% in maternity for qualified nursing and midwifery staff. This is above the trust target of 4.0% for Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital.

The breakdown by site was as follows:
- Birmingham Heartlands Hospital: 5.0%
- Good Hope Hospital: 4.0%
- Solihull Hospital: 9.1%

Managers we spoke with told us that the rate of sickness at the birthing unit had improved significantly, when we inspected there were currently no staff off sick during our inspection.

Staffing levels were displayed on the birthing unit, we observed rotas for one month for the birthing unit and the community teams that met the staffing levels required. If staffing was compromised due to sickness, staff we spoke with could describe how to escalate staffing concerns to senior midwives. We did not observe staffing issues within the birthing unit and community teams.

Incidents

The service reported safety incidents well, staff recognised incidents and reported them appropriately.

All staff could explain the importance of reporting incidents and the process of reporting. Staff were supported to report incidents. Incidents were reported electronically staff told us that they could request feedback if they wanted.

Staff could describe their responsibilities regarding the duty of candour (DoC) regulation and when this needed to be implemented. This is a regulation that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Never Events

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

University Hospitals Birmingham NHS Foundation Trust

From April to July 2018, the trust reported no incidents classified as a never event for maternity services.

Heart of England NHS Foundation Trust
We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From August 2017 to March 2018, the trust reported no incidents classified as a never event for maternity services.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

A serious incident (is an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened). We reviewed three serious incident investigations and found that there was a team approach to the investigation, a root cause analysis was performed to identify learning. All had defined action plans with named staff to take responsibility to complete the action identified.

Staff we spoke to said learning from serious incidents was shared with staff in the maternity governance meeting, the newsletter and by email.

We spoke with the leads of the service who told us that they received about 250 incidents a month for the three sites. At the time we inspected there were a small number 30 that remained open and were overdue. These incidents were low or no harm, the service did not have moderate or severe incidents that remained overdue.

Incidents across the three sites were being graded according to risk and harm, however we were not assured that the grading of some incidents was appropriate. For example, we saw incidents where women had significant bleeding following the birth which is not expected and requires further management and treatment which had been graded as no harm. Other incidents included women who had experienced serious perineal trauma because of childbirth and babies born after 37 weeks gestation who had an unexpected admission to the Neonatal Unit for enhanced care and treatment which was also graded as no harm. We raised this with the trust at the time of our inspection. Service leads explained they considered the grading of all incidents but any incidents where there was no “avoidable” harm were likely to be downgraded to low or no harm. We could not be assured that incidents were graded appropriately according to harm.

We saw root cause analysis investigations had taken place in relation to serious incidents. (Root cause analysis is an approach for identifying the underlying causes of why an incident occurred). We reviewed the serious investigation reports for four maternity incidents and saw there had been a full investigation with input from the multi-disciplinary. Learning from the incident had been recorded along with agreed actions, for example reviewing guidelines or changes to practice and escalating concerns to senior medical staff.

Staff understood their responsibilities about the Duty of Candour (DOC) regulation and were aware of the trigger for the application of duty of candour, which was for moderate harm and above. DOC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

**University Hospitals Birmingham NHS Foundation Trust**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in maternity which met the reporting criteria set by NHS England from April to July 2018.

This occurred at Birmingham Heartlands Hospital in June 2018 and related to a maternity / obstetric incident: baby only (this include foetus, neonate and infant).
Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2017 to March 2018.

The breakdown by type of incident reported were:
- Maternity/Obstetric incident: baby only (this include foetus, neonate and infant) with three incidents (75% of total incidents)
- Maternity/Obstetric incident: mother and baby (this include foetus, neonate and infant) with one incident (25% of total incidents)

Site specific information can be found below:
- Birmingham Heartlands Hospital: three incidents
- Good Hope Hospital: one incident

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment that was planned and delivered in line with current evidence based guidance.

We observed that the care and treatment was in the main managed in accordance with national guidance. For example, the Royal College of Obstetricians and Gynaecologists (RCOG) ‘Safer childbirth: minimum standards for the organisation and delivery of care in labour’ and the National Institute for Health and Care Excellence (NICE) guidance.

Trust wide policies and procedures were available on the intranet. We reviewed the guidelines on inspection, the service had 105 guidelines of which 29 (28%) were out of date. We raised this and service leads told us this was improving. The service was working with other providers in the local maternity system, the Birmingham and Solihull United Maternity and New-born Pathway (BUMP) to produce joint guidelines, which we were told made the process slower. The guideline’s midwife post had been vacant from December 2017 and had been funded for 18 hours per week by BUMP from November 2017, but the trust had not directly funded any hours. During the time there was no guideline midwife, there was a lead consultant obstetrician for guidelines, however guidelines did not have a high priority and many passed their renewal date. Since the new appointment at least 27 guidelines had been renewed. However, this meant that we did not have assurance that all guidelines were in line with any new evidence or recommendations and women might be getting the safest and most effective care and treatment.

We reviewed the clinical audit programme provided by the trust following the inspection. Topics for audit included consent and documentation, elective caesarean section, perineal trauma, induction of labour, shoulder dystocia, sepsis, intrapartum fetal monitoring, massive obstetric haemorrhage, small for gestational age babies, reduced fetal movements and antenatal screening. Staff told us monthly meetings were held to track progress and learning, however we did have any audit outcomes to review.

Care was planned according to the women’s holistic needs, we observed mainly that care and
Treatment was delivered in line with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidance. For example, fetal growth was monitored from 24 weeks by measuring and recording the symphysis fundal height (from the top of the mother’s uterus to the top of the mother’s pubic bone) at each midwifery appointment. This was in accordance with MBRRACE-UK 2015 and NICE CG62 antenatal care for uncomplicated pregnancies 2018 guidance.

Women accessed antenatal appointments in line with the NICE Antenatal Care Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy in all settings that provide routine antenatal care.

**Nutrition and hydration**

*Staff assessed women’s nutrition and hydration needs appropriately.*

The service was accredited with the UNICEF Baby Friendly Initiative (BFI) level two and were awaiting assessment for full accreditation which was due in January 2019. We saw that the unit promoted the important health benefits of breastfeeding for mother and baby. We saw information posters available.

Community midwives we spoke with told us they followed the guidelines for babies with jaundice and weight loss. They were able to check jaundice levels and baby weights in the community to prevent unnecessary admissions, midwives would refer any concerns or anomalies to the paediatricians in the hospital to ensure those babies had a medical review.

Staff told us they provided infant feeding support for women in the community if they needed it. There were also baby cafes where women could attend for peer support and further advise.

An infant feeding coordinator provided training for staff to enable all staff to support women in their feeding choice. Data obtained during the inspection showed that the current breastfeeding initiation rate was 71% this was above the trust target of 70%.

If women chose to stay following the birth of their baby they were offered a range of meals to choose from to meet nutritional needs and accommodate those with specialist religious or cultural dietary needs. Women could have food and drink in early labour.

**Pain relief**

*Staff assessed, managed and reviewed women’s pain relief effectively.*

A variety of pain relief sources was available to women including oral pain relief, injections and gases such as pain relieving gas known as (gas and air). Women could attend hypnobirthing classes with their birth partner to be taught how to self-meditate to relax them and reduce pain in labour.

A birthing pool was available for women to choose water emersion for pain relief in labour.

Staff we spoke to said pain relief was discussed with women at parenting classes and at the antenatal appointment where their birth plan was discussed. We were not able to speak with women who had birthed at the MLU.

**Patient outcomes**

*Information about outcomes was routinely collected and monitored. This was benchmarked with other maternity services to promote learning.*
The service collected data and monitored this by maintaining a maternity quality dashboard. Indicators included those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008.

The service followed the grow programme to contribute to the NHS England ambition to improve maternity outcomes. This was in line with the Secretary of State for Health's national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries in babies by 2030, with a 20% reduction by 2020.

The home births were offered to low risk women; the rate was 0.76% from April 2018 to September 2018. This was below the national average.

The community midwives educated women on the issues of smoking in pregnancy and directed them to their GP or the local services to help them to give up. The women received information and a carbon monoxide monitoring at booking. NICE Smoking: stopping in pregnancy and after childbirth (June 2010) recommends regular monitoring which indicates more than once. We escalated this to the managers, and the service did not have a guideline to support this practice.

Antenatal key performance indicators (KPI) monitored performance against nine NICE maternity standards. Performance was monitored for seven of the standards against either acceptable (green) or achievable standards (amber). Trust wide data provided following the inspection showed the service exceeded the achievable standard in one of the KPIs (ID2 – timely assessment of women with hepatitis B), had acceptable performance in five of the KPIs, but did not meet the standard (red) for one of the KPIs (NP2 – Newborn and Infant physical examination (NIPE) timely assessment of developmental dysplasia of the hip). The trust’s performance was 75% against the acceptable level for this standard of 95%.

Babies born at home or on the midwifery led unit would receive an appointment to have a hearing test performed.

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)**

**University Hospitals Birmingham NHS Foundation Trust**

The trust did not take part in the 2017 MBRRACE audit due to it being the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust.

**Heart of England NHS Foundation Trust**

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 7.15. This was more than 10% higher than the average for the comparator group of 6.2, placing it in the red band.

(Source: MBRRACE UK)

Service leads told us the MBRRACE data indicated they were not an outlier in comparison with other maternity services in the local area. The published Public Health Outcomes Framework (August 2017) illustrated the areas where Birmingham performed badly and these included infant mortality and the low birth weight of term babies which was 50% higher than the England average. Service leads told us the still birth rates had improved in 2017 and they were working with other providers in the local maternity system, the Birmingham and Solihull United Maternity
and New-born Pathway (BUMP) to further reduce stillbirth, neonatal deaths and extended perinatal mortality rates.

**Competent staff**

Maternity staff were trained to have the correct qualifications, knowledge and skill to perform their role.

The service had processes in place to identify training needs and compliance, and address any issues identified. We reviewed the trust’s Professional Midwifery Service standard operating procedure (SOP) which outlined the structure of the support that would be provided to midwives. The SOP gave clear roles and responsibilities for practice development midwives, professional midwifery advocates and the preceptorship midwife.

Some midwives had completed the acute illness management (AIMs) course which covered the identification and escalation of a deteriorating woman, to care for women in the high dependency beds. The in-house training programme commenced in June 2017 and was included on the service’s TNA. It was planned for all midwives to be trained and recertified on a four-year rolling programme. The training was initially targeted at band 6 and 7 midwives and, data provided by the trust demonstrated that 65 midwives (27%) had completed the course. Trainers were senior midwives with either a teaching qualification or had undertaken a “train the trainer” course. All staff we spoke with said they had the correct qualifications and skills to carry out their roles effectively. For example, midwives from the community were offered extra training before covering shifts in the birth unit.

Managers supported staff through the process of revalidation with their professional body the nursing and midwifery council.

**Appraisal rates**

All staff told us that the service supported staff to receive appraisals and they found them meaningful.

From April 2017 to March 2018, 86.1% of staff within maternity care at the trust received an appraisal. This is above the trust target of 85% for Birmingham Heartlands, Good Hope and Solihull Hospitals.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>31</td>
<td>31</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>382</td>
<td>439</td>
<td>87.0%</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>60</td>
<td>69</td>
<td>87.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>72</td>
<td>90</td>
<td>80.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>14</td>
<td>21</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

**Solihull Hospital**

From April 2017 to March 2018, 77.3% of staff within maternity care at Solihull Hospital received an appraisal. This is below the trust target of 85% for Birmingham Heartlands, Good Hope and Solihull Hospitals.
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Completed</th>
<th>Required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>34</td>
<td>44</td>
<td>77.3%</td>
</tr>
</tbody>
</table>

Staff told us they attended continual professional development and learning opportunities which were fully supported by their manager. Managers told us that their appraisal completion had improved.

Managers told us they were adopting the EQUIP model to replace the supervisor of midwife role, which discontinued April 2017 due to changes in legislation. However, all staff we spoke with were not aware of any changes to replace midwifery supervision.

New members of staff completed a structured induction programme and all new staff were required to complete an induction booklet, which was signed off by the ward manager.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit women and babies.

Although there were no medical staff within the unit staff described good working relationships and support from their midwife and medical colleagues within the high risk consultant led units.

Staff told us that the ambulance service responded quickly to requests to transfer women or babies who became high risk. They told us there had never been a delay reported.

Community midwives told us they had good communication and working relationships with their community colleagues such as health visitors, family nurse practitioners, GP’s and social services. This ensured detailed handovers of care.

Community midwives were based at GP surgeries and small teams of community midwives had portfolios of women attached to the surgery.

**Seven-day services**

Women could access services when they needed to.

The birth unit was accessible 24 hours a day seven days a week. Community midwives made home visits and held antenatal and postnatal clinics seven days a week and provided a seven-day, 24-hour home birth service.

**Health promotion**

Staff were consistent and proactive in supporting women to live healthier lives. Staff offered a range of health promotion advice to women accessing maternity services.

Community midwives assessed women at the initial antenatal booking visit and offered the following support throughout the pregnancy if identified: weight management, smoking cessation advice, breastfeeding advice and manual handling advice was included.

Healthy eating and weight management advice was also provided for women both before, during and after pregnancy.

Influenza and whooping cough vaccines were offered to all pregnant women after 20 weeks gestation, by community midwives. We saw posters promoting the vaccines.

Women were offered screening for sexually transmitted diseases at booking. Any positive results would be managed by the ante-natal screening midwife who contacted the woman to arrange an appointment for discussion and treatment.
Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff obtained and described consent to care and treatment in line with legislation.

Staff understood their roles and responsibilities under the Children’s Act 1989, the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.

We observed staff gaining verbal consent during an antenatal appointment. The midwife provided as much information as possible before gaining consent to perform observations and providing blood forms.

Verbal consent was also gained prior to examinations, this was evident in records that we reviewed. All midwives we spoke with understood the importance of the law relating to Fraser guidelines and Gillick competencies when caring for a female under the age of 16. The Fraser guidelines refer specifically to consent for sexual health services, and are an additional guideline to the Gillick competency framework that relates to consent for any healthcare intervention.

Mental Capacity Act and Deprivation of Liberty training completion

The trust did not provide data for completion of mental capacity and DoLS training courses for staff at Solihull Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff treated women with kindness during all interactions we observed.

Staff were kind and considerate when caring for women. We observed staff providing support to women when caring for their baby.

Feedback from women and their partners was displayed on the walls within the unit. The feedback was positive regarding their experiences for example “I have had all four of my children in this hospital and each time I cannot say anything but good things”

We met a woman and her partner who attended the birth unit for a postnatal check they informed us that staff were kind and caring.

During an antenatal appointment we observed empathy and compassion from the midwife to the women during a difficult conversation.

Friends and Family test performance

University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

Friends and family test performance (antenatal), University Hospitals Birmingham NHS Foundation Trust
The trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was suppressed due to low figures in April and May 2018. In June 2018 the trust’s performance was lower than the England average.

Friends and family test performance (birth), University Hospitals Birmingham NHS Foundation Trust

From April to June 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was consistently worse than the England average.

Friends and family test performance (postnatal ward), University Hospitals Birmingham NHS Foundation Trust
From April to June 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

Friends and family test performance (antenatal), Heart of England NHS Foundation Trust

* Data suppressed due to low number of responses

From July 2017 to March 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was consistently worse than the England average.

Please note – no data is available for November 2017 from NHS England for any trust due to data quality issues.

Friends and family test performance (birth), Heart of England NHS Foundation Trust
From July 2017 to March 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was consistently worse than the England average.

*Please note* – no data is available for November 2017 from NHS England for any trust due to data quality issues.

**Friends and family test performance (postnatal ward), Heart of England NHS Foundation Trust**

From July 2017 to March 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

*(Source: NHS England Friends and Family Test)*

**CQC Survey of women’s experiences of maternity services 2017**
University Hospitals Birmingham NHS Foundation Trust

The trust did not participate in this survey due to it being the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

The trust performed similar to other trusts for 15 out of 16 questions in the CQC maternity survey 2017 and worse for one question ‘During your labour, were you able to move around and choose the position that made you most comfortable?’

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.71</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.22</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.60</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>9.21</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.09</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.95</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.48</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.35</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>8.74</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.43</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.58</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.96</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.29</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.73</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.48</td>
<td>About the same</td>
</tr>
</tbody>
</table>
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

| 3.52 | About the same |

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

**Emotional support**

Staff supported women to cope emotionally with their pregnancy, birth, postnatal care and treatment.

Staff we spoke with told us that women’s wellbeing was monitored throughout all the stages of pregnancy, childbirth and the postnatal period.

Women could be referred to birth afterthoughts to de-brief complex experiences with a specialist midwife.

Women could access bereavement counselling if necessary, the community midwives would refer women who required this service.

**Understanding and involvement of patients and those close to them**

Women and their families were supported and involved in making decisions about the care they received.

Staff encouraged women and their family members to be partners in their care and in making decisions. We observed staff spending time talking to women and those close to them.

During a consultation we heard staff communicating to women and their families in a way that they could understand their care, treatment and advice.

Parents we spoke to told us that staff had involved them with the care they received and they were encouraged to ask questions. One woman said, “Thank you so much for all your help the two midwives were amazing”

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service was planned and provided services in a way that met the needs of people.

Facilities and premises were appropriate for the services being delivered.

Women received a home from home experience and their partners were able to have open visiting to stay with women and their baby.

During the postnatal period if a woman’s mental health was a concern the midwives would refer to the mental health team. Staff we spoke with said that referrals were dealt with efficiently and in an emergency, they would refer women to attend the urgent and emergency care department to be seen.

Information leaflets were available covering a variety of pregnancy related topics. However, there was limited availability of accessible information in different languages, picture formats, and cue cards

The trust offered car parking facilities for the public to access. We were not made aware of any issues or difficulties with this provision whilst we were on inspection.

**Bed Occupancy**
University Hospitals Birmingham NHS Foundation Trust

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust in this analysis. Because it related to the same legal entity we have used this to form part of our judgement.

From April to June 2018 the bed occupancy levels for maternity was 68%, which was higher than the England average of 59%.

Heart of England NHS Foundation Trust

We included this data item from the acquired Heart of England NHS Foundation Trust where no more recent data was available. We only provided this for contextual purposes and it did not form part of our judgement.

From January 2017 to March 2018 the bed occupancy levels for maternity were generally higher than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

Meeting people’s individual needs

The service considered the needs and choices of different women.

The majority of postnatal checks were carried out in the community, however the community midwife arranged some with women who were able to attend the unit, this avoided them waiting in all day and assisted with the community workload.

Staff took into account women’s’ individual needs and we observed detailed assessments and care plans in all eight of the records we reviewed.
The service used a language line service for women whose first language was not English. Specialist midwives were employed to support infant feeding, antenatal screening, fetal medicine, bereavement and education.

There was a team of midwives managed by the named safeguarding midwife to support women with the following issues; domestic abuse, teenagers, alcohol and substance misuse, vulnerable, homeless and asylum-seeking women and female genitalia mutilation.

Some birth unit midwives and community midwives were trained and able to perform the newborn and infant physical examination to ensure babies received the check in a timely manner.

Mental health assessments were discussed with women throughout their pregnancy. Staff told us that if a concern was identified they could access support from the mental health midwife and perinatal mental health team.

Community midwives provided a range of parentcraft classes at venues across the community for women to access. It was a rolling programme which included topics such as infant feeding, pain relief options and the stages of labour.

**Access and flow**

**Women were able to access care and treatment in a timely way.**

Community midwives performed booking appointment and antenatal checks at the women’s doctor’s surgery or within their home.

Women were given a list of contact numbers at their first appointment to enable them to access advice at any time.

Women who missed antenatal appointments were followed up at home by the community midwifery team.

**Learning from complaints and concerns**

**The service investigated concerns and complaints appropriately.**

All staff we spoke with were aware of the complaints processes.

Staff we spoke with told us that should a woman or partner raised a concern they would apologise, encourage a discussion and try and resolve the concern, if this was not possible they would direct the woman to the formal complaints process.

Managers we spoke to told us if a formal complaint was made they were managed in confidence, with a regular update for the complainant. The Patient Services Department (PSD), formerly Patient Advice and Liaison Service (PALS) passed formal complaints to the maternity risk team and managers and these were completed and returned to PSD. Managers discussed the complaints at team meetings.

The Trust website also gave information on how to make a complaint, however there was no information relating to NHS Complaints Advocacy Services. We observed information posters asking women to share their experiences. Leaflets were not available in different languages.

**Summary of complaints**

From April 2017 to March 2018 there were 11 complaints about maternity services across the trust as a whole. The trust took an average of 25.5 working days to investigate and close
complaints. This is in line with their complaints policy, which states complaints should be resolved within 30 working days.

Of the two complaints still open at the time of reporting both had been open longer than the trust target of 30 working days, the longest being open for 68 working days.

A breakdown by site is below:

- Community location: One complaint related to care received at a GP practice and was for communication/information to patients (written and oral)

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Number of compliments made to the trust**

From April 2017 to March 2018 there were seven compliments within maternity.

The breakdown by site is shown in the table below.

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solihull Hospital</td>
<td>1</td>
<td>14.3%</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

**Is the service well-led?**

**Leadership**

Managers locally and on the senior team within the service had the correct experience, skills to run the service, however, the senior team were not visible and approachable to all staff.

University Hospitals of Birmingham NHS Trust provided maternity services as part of the Heartlands, Solihull and Good Hope (HSG) Division 2. Group A of the division included paediatrics, neonates, community school nursing, and health visitors. Group B of the division was gynaecology, obstetrics and community midwifery. Leadership of Division 2 was by the divisional director and, within group B, there were clinical service leads, one specifically for obstetrics. The head of midwifery (HOM) was also the divisional director of operations (DOO) and described her role as more strategic than operational. In addition, there was a divisional general manager and we saw these four key personnel worked closely as a team and communicated well.

The HOM was supported by a deputy HOM and a deputy DOO, a clinical midwifery manager (matron) for the delivery suite and a clinical services site lead (matron).

We received mixed feedback from staff regarding the leadership of the service.

Staff were positive about managers at local level and said that they were visible on the birth unit. However, some midwives informed us that the senior leadership team were not visible and some staff told us they had no idea who their deputy head of midwifery and the head of midwifery were.

Managers we spoke with were proud of their staff and the care that they gave to women and babies.

Staff did not confirm that the executive team were visible and during the changes proposed regarding the future of the birth unit they had not visited during these difficult times.
Vision and strategy

All staff we spoke with were aware of the trust vision and could describe them. Posters displaying the trust vision were seen within all departments. The trust had five core values:

- Collaborative
- Honest
- Accountable
- Innovative
- Respectful

The vision for the maternity service was aligned to ‘Better Births’, the report of the National Maternity Review, published by NHS England in 2016 and the Maternity Transformation Programme. Service leads told us of the work streams currently being undertaken, working with other providers and commissioners for Birmingham and Solihull United Maternity and New-born Pathway (BUMP). This collaboration also included local authorities and voluntary organisations in the local maternity system (LMS). The vision for BUMP is that “Every woman will be empowered to access consistent, world-class and holistic care right for them, their baby and their family”.

Some of the aims and workstreams of BUMP include:

- Developing a single point of access for women in the region.
- Increasing the proportion of women choosing to give birth in midwifery led units or home births and supporting women to make informed choices.
- Creating a single maternity electronic patient record (EPR) for all pregnant women.
- Improving outcomes for women, their babies and families and the wider population which would also include a decrease in infant mortality.

The service worked collaboratively with clinical commissioning groups, other stakeholders, and service users to establish a local maternity system (LMS) known as ‘BUMP’, in response to national recommendations.

One part of the joint strategy was to develop a single clinical governance system across the LMS by March 2019, which will include a systematic perinatal mortality review process. We reviewed the monthly highlight report for BUMP, which indicated progress against the project milestones. From that report we saw a joint BUMP approach to clinical governance had been developed and they were in the process of setting up a joint perinatal mortality review and significant clinical incident review group. This had been shared with the board sub-committees responsible for quality and safety within the BUMP providers and were awaiting feedback. They were also working on a joint maternity dashboard and were reviewing indicators and RAG (red, amber, green) ratings.

Culture

Leaders did not always model inclusive supporting relationships with staff to promote a positive culture.

Staff satisfaction was mixed, staff we spoke with did not feel the culture of staff involvement was improving.

Local managers across the service continually promoted a positive culture that supported and valued staff, however we were not assured that this happened from the senior leadership team. Staff we spoke with did not feel actively engaged or empowered.

Most staff we spoke with described the senior leadership team as unapproachable, and following an initial introductory meeting felt their behaviours were dismissive and intimidating. Staff said that they would not be comfortable approaching some members of the leadership team directly with a concern.
Staff told us that they did not feel their opinions regarding the future of the birth unit were listened to and they did not feel valued by the trust.

The service promoted the freedom to speak up guardian service, staff were aware of this service and we observed posters throughout the hospital. This meant staff had someone to speak with confidentially about issues and concerns.

**Governance**

*We were not assured that the senior team or managers had good oversight of incident management within the governance processes throughout the whole service.*

Across the service there were a large number of incidents not graded appropriately which meant that they would not get the investigation and duty of candour that was required.

The three sites have been merged for 12 years however there remains silo working for example the service did not hold joint clinical governance meetings. This meant that each site would not be aware of issues within their service and could lead to practices being different.

Incidents were reviewed daily to review the severity. The service held a weekly meeting the Clinical professional review of incidents (CPRI) attended by senior staff, to identify serious incidents that required a root cause analysis investigation.

The service employed a governance lead midwife, who was responsible for reporting on quality performance, incidents, serious incidents, and lessons learnt. The service had two clinical practice tutors to support staff training and share learning identified following any lessons learnt after an investigation was completed.

Each area had a practice board displaying key messages relating to quality and risk. Changes were shared by email, lessons of the month, and there was a monthly presentation of the top risks in the service on the midwifery study days.

Staff we spoke with said they raised any quality issues to their managers who reported them to the Matron to escalate at the senior leadership meetings to be discussed. However, we reviewed minutes of two obstetrics and gynaecology quality and safety meetings, August 2018 and September 2018, we observed no attendance from the birth unit or community and no discussion regarding these areas. We also reviewed minutes of two division of women’s and children’s services divisional board & quality and safety meetings August 2018 and September 2018 we observed no attendance from the birth unit or community and no discussion regarding these areas.

We requested minutes of the monthly maternity led unit minutes. The service responded to inform us that these meetings were not minuted, therefore we had no assurance that the senior team or managers had oversight of governance within the maternity led unit.

**Management of risk, issues and performance**

*The service had arrangements in place for identifying, recording and reviewing, and managing risks.*

We reviewed the risk register sent to us, which had one identified risk for community and none for the birth unit. The risk was ‘increased risk of violence and aggression to lone workers in the community’. This was proposed 14 July 2017, we did not see any review date documented or who was responsible for the risk.

At the time of our inspection there was one risk midwife, trust wide. Service leads acknowledged this was not sufficient for the level of work generated across all three sites, and a further risk midwife had been appointed and would be in post by January 2019.

Staff told us all incidents were reviewed daily by senior staff. In addition, there was a weekly obstetrics and gynaecology risk meeting (CIRG), attended by the clinical service lead and a senior midwifery lead who reviewed all incidents raised within the service. Potentially serious or high-risk incidents were scoped within 72 hours and reviewed by the divisional director, clinical service lead
and head of midwifery, and any immediate actions taken as required. These incidents were discussed at the Clinical Professional Review of Incidents group (CRIP) who would confirm whether it was a serious incident and whether an investigation and root cause analysis was required.

An audit trail of all actions taken in relation to any incidents was kept in the electronic incident reporting system, and staff had to complete the “lessons learned” section within the electronic record.

We reviewed the report to the Obstetrics Quality and Safety group from July 2018. This interim report identified nine workstreams that had been introduced to improve the quality and safety of maternity care which included; surgical site infection, learning from excellence, neonatal hypothermia/hypoglycaemia (cold/low blood sugars), category one caesarean section, cervical sweeping in high risk women, induction of labour and fetal monitoring. The report gave details of the aims of the projects, progress to date and the next steps.

**Information management**

The service collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards.

The maternity service collected data around activity and outcome. Maternity performance measures were reported through the maternity dashboard and displayed. The dashboard was rated red, amber and green to enable easy identification of metrics that were better or worse than expected.

The trust used a combination of paper and electronic records for women who used the maternity service. Most of the woman’s care was recorded electronically however standardised notes developed by the Perinatal Institute were used for intrapartum care. Service leads told us there was a plan for all records to be kept electronically by Spring 2019. One of the key deliverable outcomes of the Birmingham & Solihull United Maternity and Newborn Partnership (BUMP) was for ‘all women would have a single, electronic personalised care plan that they have full access to by December 2018’. We reviewed the bi-monthly progress of BUMP and saw they were on track to meet this milestone.

Community midwives had personnel electronic tablet systems, to access relevant information through information management systems. Staff told us that internet connections were an issue and this had been reported. The service was about to launch new smart phones and lap top computers with improved Wi-Fi of which the staff were looking forward to receiving.

**Engagement**

The service leaders did not always fully engage staff in the service’s future development.

The birthing unit was due to change the provision for women. It was due to reduce from three birth rooms and two postnatal rooms to one birth room and one room for appointments. Staff told us that this decision was made without auditing women’s opinions or consulting the staff who worked on the unit.

Departments held ward meetings, staff told us they attended when they could and found them useful.

Administration and domestic staff we spoke with said they were part of the team and took pride in their work.

The service did not have a specific maternity voices group, this is a forum for maternity service users, providers and commissioners of maternity services to come together to design services, that meet the needs of local women, parents and their families. This forum was included within the BUMP meetings.

**Learning, continuous improvement and innovation**

Staff were committed to provide good quality care to women and their families.
Staff we spoke with did not share any new initiatives for the birth unit staff told us they were uncertain about the service plans for the future. However, service leads and managers told us that it was due to be downsized and changed to become a ‘pop-up’ midwifery led unit across the locality. The unit would provide one birth room and one room for postnatal clinics. Staff were concerned that they would no longer be able to offer postnatal overnight stays for women, their baby and birth partner.

The birthing unit and community midwives had received the placement of excellence award the University of Birmingham 2017. Student midwives had voted for the service due to the support and experiences they gained whilst with the team.

Staff told us the service was part of the first wave of NHS Improvement Maternal and Neonatal Health Safety Collaborative and were using quality improvement methodology to improve outcomes for women and babies. As part of this process the service used a process across all maternity sites called ‘Learning from Excellence’ (LFE) to encourage staff to nominate their colleagues when they recognise excellent work or practice. This process meant staff received praise from their peers and allowed others to learn and share good practice. At the time of our inspection, staff were completing paper forms, but it was hoped this would soon be electronic. Staff told us 389 LFE nominations had been received since it was introduced as a pilot in April 2017. Each person nominated received a certificate.
Community health services

Community health services for children, young people and families

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We included have data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

Information about the sites and teams, which offer community health services for children, young people and families at this trust, is shown below:

<table>
<thead>
<tr>
<th>Location / site name</th>
<th>Team/ward/satellite name</th>
<th>Services provided</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solihull Community</td>
<td>Children's Community Nursing</td>
<td>Long term nursing needs including injection therapy, chemotherapy and wound management, complex and palliative care nursing including end of life care</td>
<td>3rd Floor Friars Gate, 1011 Stratford Road, Shirley B90 4BN</td>
</tr>
<tr>
<td>Solihull Community</td>
<td>Children's Learning Disability Nursing</td>
<td>Moderate to severe learning disability nursing and family support</td>
<td>3rd Floor Friars Gate, 1011 Stratford Road, Shirley B90 4BN</td>
</tr>
<tr>
<td>Solihull Community</td>
<td>Special Schools Nursing</td>
<td>Nurse support in four special schools in the borough of Solihull; including care planning and support for children with complex health needs</td>
<td>3rd Floor Friars Gate, 1011 Stratford Road, Shirley B90 4BN</td>
</tr>
<tr>
<td>Solihull Community</td>
<td>Community Paediatrics</td>
<td>Community based general paediatrics, palliative care, medical support for adoption and fostering, behavioural and developmental paediatrics</td>
<td>3rd Floor Friars Gate, 1011 Stratford Road, Shirley B90 4BN</td>
</tr>
</tbody>
</table>
The trust provides a community paediatrics service in Solihull with the following teams/unit in place:

- **Children’s Community Nursing** - nursing / family support to children and young people with complex health needs, children with an identified long-term health need or short-term nursing need, palliative and end of life care at home.

- **Learning disabilities team** - support and management strategies to children and young people with moderate to severe learning disability at home, school and their community.

- **Special School Nursing** - any child registered at a Solihull Special School age between two and 19 years. Supporting general health of children and facilitating school attendance of children with more significant / complex health needs.

- **Community based Paediatricians** - support palliative care, adoption and fostering medicals, behavioral and developmental paediatrics including medical input to CDC, special schools and autism service, SUDI/C lead role, medical input to CDOP, child protection medicals and Designated doctor role.

The trust works closely with acute providers and primary care colleagues so children and young people are managed at home wherever possible. They also work closely with children’s therapy services, education, mental health and social care colleagues to support a holistic approach to support children and their families to access all appropriate services and support close to home.

**Is this service safe?**

**Mandatory training**

The service provided mandatory training in key skills for all staff and most staff had completed it.

Staff told us they were required to attend one full day of all required mandatory training every two years. The training included infection control, moving and handling, basic life support and safeguarding children level three. The matron and team leaders told us staff were notified electronically three months before they were required to update their mandatory training. Team leaders and other managers were also notified and required mandatory training was then booked. Some community nursing staff told us that their mandatory training had expired but were unable to book onto a mandatory training course until January 2019.

**Mandatory Training completion**

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in community services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td></td>
<td>Number of eligible staff</td>
</tr>
</tbody>
</table>

*Source: Universal Routine Provider Information Request (RPIR) – P2 Sites tab*

*Source: Community PIR – Context tab*
### Training Compliance

<table>
<thead>
<tr>
<th>Module</th>
<th>Course</th>
<th>Attended</th>
<th>Completed %</th>
<th>Pass %</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major incident awareness</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines management</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Waste management</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>15</td>
<td>16</td>
<td>93.8%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>14</td>
<td>16</td>
<td>87.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community services for children, young people and families, the trust had an overall training compliance rate of 95.3% for qualified nursing staff. The trust’s 90% completion target was met for 11 of the 12 mandatory training modules for which qualified nursing staff were eligible. The resuscitation - clinical module had the lowest completion rate, at 87.5%.

The trust provided information that no medical staff were eligible for training between April 2017 and March 2018.

(Source: Routine Provider Information Request (RPIR) – Training tab)

### Safeguarding

Staff understood how to protect patients from abuse and had training on how to recognise and report abuse and they knew how to apply it.

Staff had a good understanding and awareness of abuse and neglect and took actions to prevent children being put at risk of harm. Staff visited children, young people and their families regularly getting to know them well and identify potential abuse and neglect. We saw this during one multidisciplinary meeting we attended. Some children and young people who used the service had behaviours that challenged and could be both violent and abusive to those around them which made them and to others vulnerable. Staff identified when parents needed help and provided early help and support to them including management strategies and respite including the ‘short breaks’ initiative.

The service worked with other agencies to ensure the ‘Working Together to Safeguard Children 2015 principles were central to their work. We attended one safeguarding meeting and one serious case review and observed multiagency arrangements in place to ensure children who were at risk were identified and kept safe.

All looked after children identified by the local authority had a medical undertaken by the community paediatrician when they were referred to the service. The medical included a full review of their physical, mental health and any actual or potential safeguarding concerns. Following the medical all children were reviewed 30 days later by a looked after children’s nurse. Further medical review was undertaken by a community paediatrician with the timing dependent on the child’s or young person’s need but no longer than 12 months since their last review. We saw he reviews all included a safeguarding assessment.
Community children’s nurses had regular supervision with the trusts safeguarding lead nurse who visited the service one to two days every week. Special school nurses had three monthly safeguarding supervisions within the school in addition to safeguarding supervision from the trust safeguarding children’s lead nurse. Staff told us they could access safeguarding advice and supervision at other times Monday to Friday if they felt extra advice or support was required.

The supervision reviewed actions undertaken to identify both actual and potential abuse and neglect to ensure children were kept safe. The matron told us they also discussed safeguarding during weekly team meetings.

Special school nurses told us they had regular level 3 children’s safeguarding training with additional training from the local children’s safeguarding board which included female genital mutilation, domestic abuse, forced marriage and PREVENT training.

Staff and managers told us they had regular safeguarding supervision to ensure appropriate and timely actions were taken to safeguard children and young people.

**Safeguarding Training completion**

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Staff required to undertake the training</th>
<th>Total staff</th>
<th>Number trained</th>
<th>Current Compliance</th>
<th>Trust target of 85% met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safeguarding Children &amp; Adults Level 2</strong></td>
<td>Community children’s nurses (CNN); Looked after children (LAC) &amp; Special School Nurses</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Safeguarding Adults Level 2 training within 3 yrs</strong></td>
<td>CNN; LAC &amp; Special School Nurses</td>
<td>19</td>
<td>6</td>
<td>32% *</td>
<td>No</td>
</tr>
<tr>
<td><strong>Safeguarding Children Level 3</strong></td>
<td>CNN; LAC &amp; Special School Nurses</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Safeguarding Children Level 3 within 3 yrs (incorporating Level 2)</strong></td>
<td>CNN; LAC &amp; Special School Nurses</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Safeguarding Children Level 4 within 3 yrs</strong></td>
<td>Named Nurse for LAC</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Adults Level 2</td>
<td>Paediatric Physio &amp; Early Years SALT</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------------------------------</td>
<td>----</td>
<td>----</td>
<td>-------</td>
<td>-----</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Adults Level 2 within 3 yrs</td>
<td>Paediatric Physio &amp; Early Years SALT</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>Paediatric Physio &amp; Early Years SALT</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 within 3 yrs (incorporating Level 2 for children)</td>
<td>Paediatric Physio &amp; Early Years SALT</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Adults Level 2</td>
<td>Dieticians, OT, Physios, SALT</td>
<td>33</td>
<td>30</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children &amp; Adults Level 2 within 3 yrs</td>
<td>Dieticians, OT, Physios, SALT</td>
<td>33</td>
<td>30</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 within 3 yrs (incorporating Level 2 for children)</td>
<td>Dieticians, OT, Physios, SALT</td>
<td>27</td>
<td>24</td>
<td>89%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 2</td>
<td>Community Paediatrics Medics</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>Community Paediatric Medics</td>
<td>5</td>
<td>4</td>
<td>80%*</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 within 3 yrs</td>
<td>Community Paediatric Medics</td>
<td>5</td>
<td>1</td>
<td>20% *</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 (inc Level 2 Safeguarding)</td>
<td>Community Paediatric Medics</td>
<td>5</td>
<td>5</td>
<td>100%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
All but one staff group met the trust target for required children’s and adults safeguarding training. The trust had identified Safeguarding Adult Training Update for Children’s Community Services had been scheduled for Quarter 3 (between September and December 2018).

(Source: Trust information DR257)

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

The trust was unable to split out the safeguarding referrals in community services for adults and children, reporting 73 between April 2017 and March 2018 for all community services.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Cleanliness, infection control and hygiene

The service mainly controlled infection risk well although there was a need to ensure staff highlighted where improvements were required to further protect people against the spread of infection.

We observed clinic areas were visibly clean. There were daily cleaning rotas in place which confirmed all areas had been cleaned at the required frequency (such as twice a day).

The service conducted monthly ‘essential steps audits which included hand hygiene, and sharps management. The children’s community service had 100% compliance with hand hygiene and sharps management for the last six months (shown below).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance %</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source trust information DR 262)

The service did metrics audits which included the availability and use of gloves and aprons, hand gel, cleanliness of equipment and whether staff wore the appropriate uniform (which included arms bare below the elbows). The service identified they did not undertake environmental infection control audits because care was undertaken within the child or young person’s home. However,
we found a need to ensure environmental audits are taken where staff provided care to identify potential risks.

We saw that staff washed their hands appropriately and carried hand gel in addition. Staff followed best practice and had arms ‘bare below the elbows’. Although hand cleansing facilities were mostly appropriate we observed unsuitable and insufficient hand washing facilities at one special school. Staff were having to wash their hands in a sink used for washing crockery and there was no hand washing sink available in a treatment room used by the physiotherapist. Whilst we observed staff washed their hands or used hand cleansing gel appropriately this was problematic when insufficient hand washing facilities were available. There was also no pedal operated bin available within the same school which does not meet infection control requirements. Staff had not highlighted handwashing facilities were unsuitable.

Single use items were used once and then disposed of appropriately. We saw that there were appropriate arrangements in place for the disposal of needles and syringes, although staff told us arrangements with Solihull Borough Council were to ‘double bag' incontinence and sanitary and dressing products prior to disposal within domestic waste to go to landfill. However, one head teacher told us the school had a contract to dispose of clinical waste which included incontinence and sanitary products. There was a need to ensure correct arrangements for the appropriate disposal of clinical waste.

Environment and equipment

The service mostly had suitable equipment to meet children and young people’s needs however the lack of essential suitable scales to weigh children may mean they did not receive appropriate treatment.

Most children and young people’s care or treatment was provided within their own home or within the special schools and not part of the trust. Community paediatric therapists had recently moved to a primary care centre. We spoke with the manager who told us a health and safety assessment of the premises had been undertaken prior to the therapists moving there (included ligature risks, electrical socket safety and non-slam doors. The environment was suitable for children including children with mental health needs, autistic syndrome disorder (ASD) attention deficit/hyperactivity disorder (ADHD).

The service did monthly ‘metrics’ audits. The audits included equipment such as syringe drivers, equipment to replace specialist feeding tubes and lifesaving equipment such as suction and breathing monitors. Staff audited the availability and whether the equipment maintenance was in date. The metrics audits for each service area such as community children’s nursing, special schools and learning disability nurses. We saw that most equipment had a record to confirm it was regularly serviced and maintained, however, one electronic blood pressure machine had a date for service recorded as September 2016. The school nurse immediately removed it for service.

Whilst staff told us they weighed children frequently we saw that ‘stand on’ scales only were available in one special school. The special school nurse said the ‘sit on scales’ had been removed the week before and were no longer available. They said they would encourage the child to stand on the scales when they next needed a weight review. However, we saw that not all children would be able to stand and may be risk of falling should they attempt to. The matron told us the school had hoist scales but the school nurse did not confirm that alternative scales were available. The lack of suitable equipment meant not all children or young people could be appropriately weighed.

Assessing and responding to patient risk

The service planned for emergencies and staff understood their roles if one should happen.
Children with life limited illness had individual care plans with symptom flow charts. The symptom flow charts identified increased symptoms and would trigger a need for referral to a community paediatric consultant. Information we saw during the inspection confirmed timely arrangements were made for the child to be reviewed and treated when possible within their own home. The symptom flow charts were part of children’s palliative care pathway and were developed by West Midlands Paediatric Palliative care group.

The children’s nursing service used a sepsis indication chart if there were any concerns about potential infection. The flow chart identified when need for referral was need either to accident and emergency or their doctor.

Special school nurses had care plans for children and young people within the school with a medical need. The plan of care included any medicines they were prescribed as well as specialist feeding regimes and care in an emergency.

We found most children and young people had a plan of care in place which included actions to be taken if there were any concerns out of hours such as rescue medicines and clear instructions to call 999 identified within the plan of care. Although we found there was no information identified for children within the learning disability service about what actions they should be taken in a crisis. The learning disability service leaflet also did not give families information about whom or what service they should contact in a crisis both within normal operating hours and out of hours.

We saw a letter was sent to their parents or carers to confirm their child was on the waiting list to be seen by a learning disability nurse. However, the letter did not include information to identify if there were any changes or deterioration in condition actions they should undertake. We found further review of children did not take place when they were on the waiting list. This meant there was they may not be seen in a timely way if there was a greater urgency for treatment.

The community learning disability nurse service told us they could refer children/ young people to the crisis team in urgent situations.

**Nurse Staffing**

The service generally had sufficient staff with the right qualifications, experience and training to keep children and young people safe from avoidable harm and abuse and to provide the right care and treatment. However, in some services due to smaller staffing groups it struggled during staff absence to provide the timely care and treatment.

The learning disability service was staffed with four learning disability nurses which was its full staffing establishment. The matron told us that one nurse was on maternity and another on long term sick leave which meant that the service was without 50% of its required nurses which had resulted in a delay supporting and reviewing children and young people with a learning disability on the waiting list. They told us they had a bank nurse for one day which had been a valuable addition to the team.

The services provided nursing support to four special schools within Solihull. Two schools had a school nurse available 8.30am to 4.30 pm Monday to Friday. The remaining two schools had a school nurse onsite one day a week and telephone advice and support when needed at other times. The special school nurses had a band 6 whole time equivalent team leader, one band 5 nurse (currently wte but providing maternity leave cover for a 0.8 wte). We saw information during our inspection to confirm funding had been agreed to maintain this post as full time. A full-time post ensured the school nurse was available when children arrived, during the school day and until all the children had gone home. One 0.4wte (3 days), one band 4 health care assistant and one band 2 health care assistant each supported the team over four days. All school nurses were
employed on term time only contracts. Information we saw during the inspection identified this was an issue when information was required during school holidays.

The community children’s nursing team had three band 6 nurses (two WTE posts), five band 5 nurses (3.8 WTE posts), and a band 3 health care support worker. The community nursing caseload was between 10 and 20 children and young people at any one time. There were sufficient nursing staff to meet children’s needs.

**Planned v Actual Establishment**

The trust has reported their staffing numbers for March 2018 and June 2018 community health services for children, young people and families by staff group as below.

The trust reported that the service was over capacity for both time periods with a fill rate of 102.2% in March 2018 and 107.2% in June 2018. This relates to an overfill of 2.3 WTE members of staff in June 2018.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff – WTE</td>
<td>Planned staff – WTE</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>4.6</td>
<td>4.1</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>8.5</td>
<td>7.9</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>15.4</td>
<td>15.3</td>
</tr>
<tr>
<td>Support to scientific, therapeutic &amp; technical staff</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>0.0</td>
<td>0.5</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Medical staff, qualified nursing staff and qualified allied health professionals are all above their planned staffing rate, however due to the small numbers involved this is only a small number of staff.

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

**Vacancies**

From April 2017 to March 2018, the trust reported a vacancy rate of 15.8% for nursing staff in community services for children, young people and families. This was higher than the trust target of 5%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover**

From April 2017 to March 2018, the trust reported an overall turnover rate of 28.6% in community health services for children, young people and families. This exceeded the trust's target turnover.
rate of 8.5%.

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

**Sickness**

The trust set a target of 4.0% for sickness rates. From April 2017 to March 2018, the trust reported an overall sickness rate of 7.0% in community health services for children, young people and families with a sickness rate of 6.7% for qualified nursing and health staff. This did not meet the trust’s target of 3.6%.

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

**Nursing – Bank and Agency Qualified nurses**

Staff in all services told us due to the complex challenges most children and young people who used the service had they did not use agency staff. We were told that the learning disability team had a bank nurse for one day a week which provided a valuable addition to the team. The trust reported there were 12 qualified nursing shifts filled by bank staff, none by agency staff and no shifts left unfilled in community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

**Nursing - Bank and Agency Non-Qualified nurses**

The trust reported there were 12 non-qualified nursing shifts filled by bank staff, none by agency staff and one shift left unfilled in community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

**Medical locums**

From April 2017 to March 2018 the trust reported did not report any locum, bank or unfilled shifts for medical staff in community health services for children, young people and families.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

**Quality of records**

Staff mostly kept appropriate and up to date records of children and young peoples’ care and treatment. Whilst paper patient records were available access to electronic records in one special school meant full and up to date records were not available to fully review and assess children.

The service used both electronic and paper records. We saw that there were contemporaneous records of each child and the care they received. There was a record of an initial assessment which included their past medical history, family relationships, general development and wellbeing and assessments such as continence assessments and mental capacity assessment. Within the special school records included a daily journal which identified care provided to the child during
their school day. When applicable the notes would be tagged to identify the child was part of safeguarding processes.

We saw within each service we visited there were health assessment records in place which included an identified plan of care in place. However, we saw that risk assessments which may include nutritional, pressure ulcer and behavioural risks were not consistently available. School nursing staff told us risk assessments were completed by other community nurses but we found this was inconsistently undertaken particularly if the child lived outside Solihull Borough but went to one of the for special schools.

Within the learning disability nursing record risks assessments were not always available such as a risk that challenging behaviour may have on others. The matron told us after the inspection they were putting these risk assessments in place.

All community nursing services completed monthly 'metrics' audits which included the completion and management records. We saw that compliance with record keeping standards was mostly good but when standards were not met and required improvement action was clearly identified.

Staff told us and we observed there was no information technology link at one special school since September 2018. Staff told us they were unable to check electronic records whilst in the school; such as the child’s previous weight, historic care plans, previous clinic history and treatment plan or order continence products. This meant staff did not have complete or up to date information about the child or young person to provide safe them with safe and effective care and treatment.

The learning disability service provided information in an accessible way. However, there was no clear audit trail for review although the records identified there had been discussion about review. The care records also did not include risk assessments such as violence and aggression to self or others.

The physiotherapy service had audited patient records in January 2018. The audit identified overall 97% compliance with required standards.

**Medicines**

The service prescribed, gave, recorded and stored most medicines appropriately. However, there was a need to ensure robust arrangements for administration of non-prescription medicines.

Prescription medicines were stored safely in locked cupboards which staff accessed using their keys. There were fridges available for temperature sensitive drugs. Staff recorded temperature levels daily and these remained within an acceptable range.

Medicine in special school were stored for individual pupils with a log of each child’s/young person’s medicines, stock amount and expiry date. A care plan detailed the child/young person medicine needs and consent to administer the children’s medicines was recorded.

The management of controlled drugs was mostly in line with legislation and NHS regulations. We observed the controlled drugs cupboard in one special school did not comply with regulations and was not appropriately secured to the wall. There were controlled drug registers in place where appropriate which recorded drugs being booked into stock, administered to a patient and any destruction or return to pharmacy. Staff we spoke with were aware of the policies on the administration of controlled drugs.

Prescription charts seen mainly included all the relevant information. We reviewed 10 prescription charts. Records showed who had prescribed the medicine with instructions for administration, confirmation the medicine had been administered or the reason it was not given. All treatment
sheets we looked at included information about the child/young person including their photograph as identification. There was a record of the child’s or young person’s weight and they were regularly weighed depending on their needs. Prescriptions we looked at were appropriate for the child’s weight. The frequency of weights was advised by the doctor or a dietician dependent on the child/young person’s needs. Allergies were recorded both within the paper and electronic patients records which included the medicines administration record.

Whilst we saw that medicines management mainly met required practice we found that this was not always the situation. We saw inconsistent use of paracetamol. Two of the four special school administered paracetamol without a doctor’s prescription and used the guidance on the bottle for dosage according to the child’s age. However, some of the children weighed less than an average child and this may present a potential risk. The other two schools only gave paracetamol when it was prescribed by a doctor.

We saw that whilst there was a record for ‘as required’ medicines which included rescue medicines we saw that some records did not clearly identify the reason the medicine should be administered. We saw one child could have paracetamol but whilst it identified they had previously had convulsions due to a high temperature we later found the paracetamol was to be given for pain which they may experience due to constant head banging. We raised our concerns to leaders in the service, who were taking action to improve this in response to our concerns.

We looked at the Administration of Medicines in Schools and settings policy. It was dated January 2015 and related to the previous trust with no date identified for review.

Community nursing staff told us they had all received training in the safe management of medicines. In addition, identified staff had additional received training in the administration of medicines via other routes such as through a syringe driver of a central venous line.

Incidents relating to medication errors appeared to be low. We spoke with the matron about one reported medication error. The matron told us learning was discussed and shared within team meetings.

The team leaders carried out medicine audits. Medicines storage and controlled drugs were audited. We saw documentation of action plans to address issues identified through these audit processes.

Safety performance

The matron and we saw the children’s community nursing service completed a monthly ‘matrix’ report which identified all pressure ulcers and falls every month. We saw the matrix information was both shared with senior managers within the trust and with teams during team meetings.

Incident reporting, learning and improvement

Staff recognised most incidents and reported them appropriately however, other key incidents had not been reported. A failure to report all incidents meant appropriate investigation and learning was not in place.

Staff told us they know how to report incidents when required. They told us that lessons were shared with them during team meetings. One example given to us was when blood results had been recorded incorrectly in the patient records of their twin. The staff member told us since this occurrence they double check the right patient and check the date of birth, hospital number, NHS number and home address. The community nursing team had told the parents about the error and about the new systems now in place.
We found no incident had been reported in relation to the 24-hour cover for the children's service and possible impact on the service or when the matron struggled to get medicines required for an end of life child and had a poor response from the on-call pharmacist. Whilst we understand that staff had not questioned their involvement to ensure the child received appropriate care and treatment there was a need for this information is more widely shared and responded to throughout the trust. Staff had also not incident reported unsuitable handwashing facilities within one special school.

The learning disability nurses gave us examples of incidents they had reported which included near misses and lessons that had been learnt

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to July 2018, the trust reported no never events for community health services for children, young people and families.

*(Source: Strategic Executive Information System (STEIS))*

**Serious Incidents**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community health services for children, young people and families, which met the reporting criteria, set by NHS England between April 2018 to July 2018.

*(Source: Strategic Executive Information System (STEIS))*
Is the service effective?

**Evidence-based care and treatment**

Whilst the service provided most care and treatment based on national guidance and evidence of its effectiveness there was a need to improve transition arrangements between services.

Children and young people’s records identified they had a full initial assessment of their needs when they entered the service and the assessment was subsequently reviewed regularly. The assessment formed the basis of their plan of care and included their physical, mental health and social needs and met best practice.

The service was delivering the Healthy Child programme. The community paediatricians and community nurses did regular assessments and screening which included developmental reviews when appropriate and parental support. Vaccination programmes were provided by another local trust.

Children with long term health conditions and complex needs had a clear and up to date personalised plan of care which was in line with best practice. We reviewed seven care records which related to the learning disability service. All included an initial assessment, all care plans were personalised and had clear goals identified which involved the parent or child. The care plans were in social story format, pictorial and were easy read.

The Special Assessment Service provided a multidisciplinary approach to the assessment, diagnosis and management of autism spectrum disorders. Autism spectrum disorders affect the person’s social interaction, communication, interests and behaviour. We found the service met best practice guidelines with care and treatment provided by a multidisciplinary team with a single point of ace. However, there was an eight-month waiting list for the service which did not meet best practice and meant the child did not have timely treatment.

National Institute for Health and Clinical Excellence (NICE) identify statements of best practice to support children transitioning between paediatric to adult services. These statements identify best practice such as children from year 9 should have an annual meeting to review their transition plan, have a named worker and meet their practitioner before they move to an adult service. We asked staff about care and support that young people received when moving onto adult services. Staff told us transition work was mostly undertaken by acute services such as the diabetes and neurology teams. However, staff were unclear if this was being undertaken. We spoke with one parent they told us their teenager had been discharged from an acute paediatric service but had not been advised or given support for future appropriate care within adult services. Staff generally did not know or understand what role they should have to support children moving into adult services.

**Nutrition and hydration**

Staff ensured that children and young people had food and drink including specialist feeding when necessary to meet their needs and improve their health.

The service used a national paediatric assessment which identified nutritional intake compared to body weight and then identified if there was a nutritional risk and required actions to be taken such as referral to a dietician, referral to a consultant or monitor weight for identified time period as identified in care plan.
We saw that special school nurses and community children's nurses provided care and support for children and young people who required specialist feeding regimes.

Community nurses discussed healthy eating and how it could be incorporated as part of a ‘blended’ diet for several children and young people who required an ethnic diet.

**Pain relief**

**Pain relief was administered although a formal assessment tool to assess pain was not available.**

The special school nursing service did not use any evidence based pain assessment tool. The special school nurses we spoke said most children and young people could locate pain but not identify the severity of it. Staff said it would not be possible to use a pain assessment tool and they relied on classroom staff who knew they well to identify pain and help assess its severity.

The children’s community nurses administered prescribed pain relief in children’s and young people’s own home to keep them pain free and comfortable.

**Patient outcomes**

**The service monitored the effectiveness of care and treatment and used the findings to improve them.**

Therapy services reviewed patient outcomes every month. Information provided by the trust showed between 1 April 2018 and 30 September 2018, 65 children or young people (94.2%) achieved all or most of their treatment aims. The monthly patient outcomes identified 65 (81.3%) of children and young people who received treatment from community therapy service had a good outcome to their treatment, 11 patients (13.7%) had a poor outcome and incorrect recording for four patients (5%).

**Audits – changes to working practices**

Therapy services had an identified cerebral palsy integrated pathway (CPIP). The pathway identified three categories of patient outcomes: Green, continue with current intervention, amber and red requiring additional or alternative referral and treatment. The service had undertaken an audit of all children and young people on the CPIP pathway between September 2016 and September 2017 and identified the care pathway had been appropriately followed. Since October 2017 the service had contributed data to West Midlands CPIP database the service. The first annual report will be available from January 2019 to enable the service to compare patient outcomes and make further improvement to the service when needed.

The matron showed us a pressure ulcer risk audit that was undertaken for all neonates, infants, children and young people admitted to secondary care. The audit identified five children who were part of the community nursing team caseload and were included in the audit. We saw that all five children had an assessment of their pressure ulcer risk. There was an action plan which identified revised practice and a need to review all patients who had any identified pressure ulcer risk. When a risk was identified the nurse should provide a leaflet and advice in relation to repositioning and commence an individual care plan for the child. There had been no subsequent review as actions had only been identified to be undertaken by 1 September 2018.

**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 monitor the effectiveness of the service.**
Community children’s nurses were competent and received appropriate training in relation to their roles, including training in medical devices. Staff were trained in their specialism and had additional training and experience in the care and treatment of children. Community children’s nursing staff and special school nurses had a paediatric nursing qualification. The learning disability nurses had both a learning disability qualification and at least 12 months previous experience with children and young people. Nurses we spoke with were experienced nurses had previously worked in a range of children’s services. Allied health practitioners had undertaken further qualifications and experience in the treatment of children and young people.

New staff attended a trust induction prior to starting work within the service and had induction within the service. We spoke with a special school nurse who had been in post since September. They told us they had attended the trust’s two days induction programme after which they had been supernumerary within the school shadowing a band 6 nurse for three weeks getting to know the children, and their needs. They had also attended other training such to manage emergency situations such as asthma, anaphylaxis, sepsis and seizure management.

Nurse competencies were in place for procedures such as specialist feeding, syringe driver management, gastrostomy ‘button’ changes and medicine competencies. Completion of competencies was recorded on a central training record.

All clinical community staff had a link or a ‘champion who had additional training and experience for example in nutrition or sign language.

The community children’s team were part of the West Midlands Palliative Network. Staff could contact the network for advice when needed.

We saw that community special school role included ensuring school staff were trained and competent to provide emergency or routine care such as administration of nebulisers. We saw community nurses completed competency assessment to demonstrate training provided and assessments of staff competency.

The matron told us community paediatric nurses had required skills to support special school nurses and when needed provided cover for them.

The special school had a link learning disability nurse who provided support and advice in aspects of children’s or young person’s care such as behaviour management. We observed consultations between the learning disability nurse, parents and children. The nurse asked questions exploring all possibilities around the young people’s behaviour.

**Clinical Supervision**

Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff told us they received regular clinical supervision. Band 6 nurses had one to one meetings with nurses within their team every six weeks and every third meeting was a clinical supervision session which was recorded.

The learning disability nurses told us they had monthly clinical supervision during which they discussed their caseloads and outcomes of treatment. In addition, they had fortnightly meeting during which they discussed new referrals and their current caseloads.
The community children’s allied health professionals we spoke with told us they each had regular clinical supervision within their professional group or team. Staff told us there was a record made of each clinical supervision session.

The trust reported that they do not hold specific numeric data around individual clinical supervision and do not have specific clinical supervision targets. All employees have access to formal managerial supervision and performance is reviewed in line with the appraisal policy and procedure.

(Source: Universal RPIR – Clinical Supervision tab)

Appraisal rates

All staff we spoke with said that had received an appraisal and had a personal development plan in place. Staff told us that there was a central record of all appraisals. Staff told us they were made aware when appraisals were due to ensure they were in the diary and scheduled.

From April 2017 to March 2018, 83.3% of qualified nursing staff within the community health services for children, young people and families core service had received an appraisal compared to the trust target of 85%. No appraisal data was reported for any other staff groups in this core service.

A breakdown by team is below:

<table>
<thead>
<tr>
<th>Service/team</th>
<th>Completed</th>
<th>Required</th>
<th>Completion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special schools</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Youth offending team</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Children’s nursing team</td>
<td>13</td>
<td>16</td>
<td>81.3%</td>
</tr>
<tr>
<td>Looked after children</td>
<td>2</td>
<td>3</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

Multidisciplinary working and coordinated care pathways

Staff worked together as a team to benefit children and young people. Community paediatricians, community nurses and other health professionals supported each other to provide high quality and effective care.

There was a multidisciplinary approach to the assessment, and delivering care and treatment. There were good arrangements for multidisciplinary working which included community children’s nurses, special school nurses, paediatricians, therapists and specialist nurses such as the paediatric diabetes nurse. The special assessment team and autism were multi-disciplinary teams which assessed and provided coordinated treatment.

Health visitors worked for another local trust. Staff we spoke with said they liaised with health visitors for under-fives. They gave us positive examples of the effectiveness of this joint working, such as one child who had specialist feeding needs they had identified had lost weight and a referral was made to a dietician.
Therapists told us about developments to rotate into the mental health team. This arrangement benefitted both children with autism and children and young people experiencing mental ill health problems and included the support of a psychiatrist.

The community paediatricians, community paediatric nurses, therapists and special assessment service had access and links with the child and adolescent mental health service (CAMHS). Staff told us this provided them with excellent support and when needed could access a children’s psychiatrist or psychologist.

The learning disability nurses had monthly multi-disciplinary meetings with the CAMHS and a team of staff from across other trusts known as Solar which included a consultant psychiatrist and a consultant psychologist to discuss children and young people and their care needs.

The learning disability, and school nurses attended meetings to develop children’s and young people’s educational health care plans.

We observed a multi-disciplinary meeting within one special school. The meeting included staff from both education and health, the head teacher and safeguarding lead for education. Staff told us the meetings were held weekly. The meeting was interactive between school and health staff to promote the wellbeing of the pupils. The meeting discussed joint training funded by education with school nurses invited to attend sessions around education health care plans.

Community nurses did raise some concern about liaison between the immunization team employed by another trust who vaccinated children. They said it was sometimes difficult to identify the vaccination status of children and young people as the other trust did not use the same electronic records system.

Health promotion

Staff provided information and advice to promote children and young people’s health and wellbeing.

Community paediatric nurses provided daily health promotion advice. They weighed and measured the height of children and young people, provided advice on healthy eating and when required made referrals to a dietician.

Special school nurses and learning disability nurse provided advice and health promotion workshops to discuss healthy eating and obesity, sexual health, self-esteem, smoking and sun safety.

We saw that community nurses visiting children and parents at home all discussed the importance of flu vaccination.

Community paediatric physiotherapists told us they had undertaken awareness campaigns which included the use and lifting of school bags to prevent injuries.

The therapies service had produced an information leaflet for children and young people who had ‘hypermobility’. It described the effects of hypermobility and provided advice on pain and fatigue management, exercise, movement, posture and suitable footwear.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

There were appropriate arrangements in place to seek and confirm consent to care and treatment for children, young people and adults who had parental responsibilities.

Records we looked at and observations we made during our inspection showed that valid consent to treatment was obtained for children and young people. We found when children or young people were under 16 years consent was sought and obtained with their involvement either
directly if they were judged to be Gillick competent or from a person with parental responsibility where the child or young person was unable to give or withheld their consent.

Staff told us they encouraged young people between 16 and 18 to involve their families or carers in decisions about consent.

We observed staff asked parents for consent to share information with other health professionals or agencies.

The trusts children’s consent policy was dated 5 September 2013, to be reviewed by August 2016. The trust identified the policy and procedure for consent to treatment was currently in the latter stages of an in-depth review. The purpose of this review was to update the trust’s approach to consent considering recent high profile legal cases and ensure they were adhering to best practice across the new combined trust.

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support children and young people experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff we spoke with were knowledgably about their responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. We saw that there were appropriate discussions about capacity to make safe and appropriate decisions.

The trust told us there was a new requirement for this community children's and young people's staff to receive training in the Mental Capacity Act 2005 by January 2019. Information provided showed that they were on target to achieve the trust target.

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Staff required to undertake the training</th>
<th>Total staff</th>
<th>Number trained</th>
<th>Target</th>
<th>Current Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA training</td>
<td>CNN; LAC &amp; Special School Nurses</td>
<td>19</td>
<td>16</td>
<td>85% by the end of Q4 2018-19</td>
<td>84%</td>
</tr>
<tr>
<td>MCA training</td>
<td>Community Paediatric Medics</td>
<td>5</td>
<td>4</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust information request DR256)

**Deprivation of Liberty Safeguards**

From April 2017 to March 2018 the trust reported 621 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. The trust has not broken down this data by core service, so the above number is the overall number of applications.

The greatest numbers of DoLS applications were made in January 2018 and March 2018 with 64 applications in each month respectively.

From April 2017 to March 2018 CQC received 624 direct notifications from the trust.

Information detailed below identifies deprivation of liberty applications however deprivation of liberty safeguards does not relate to children or young people under 18 years of age.

**Number of standard DOLS applications:**
<table>
<thead>
<tr>
<th>Month and year</th>
<th>Number of applications made</th>
<th>Number of applications approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>42</td>
<td>7</td>
</tr>
<tr>
<td>May 2017</td>
<td>52</td>
<td>12</td>
</tr>
<tr>
<td>June 2017</td>
<td>50</td>
<td>9</td>
</tr>
<tr>
<td>July 2017</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>August 2017</td>
<td>49</td>
<td>9</td>
</tr>
<tr>
<td>September 2017</td>
<td>45</td>
<td>5</td>
</tr>
<tr>
<td>October 2017</td>
<td>47</td>
<td>11</td>
</tr>
<tr>
<td>November 2017</td>
<td>58</td>
<td>12</td>
</tr>
<tr>
<td>December 2017</td>
<td>45</td>
<td>13</td>
</tr>
<tr>
<td>January 2018</td>
<td>64</td>
<td>12</td>
</tr>
<tr>
<td>February 2018</td>
<td>55</td>
<td>12</td>
</tr>
<tr>
<td>March 2018</td>
<td>64</td>
<td>17</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

Is the service caring?

Compassionate care

Staff went beyond the expectations of children, young people and their families in providing care and support. They gave their own time freely to ensure patients always had expert care, even beyond normal working hours, and to raise funds for patient treats.

Feedback from parents, carers, education staff and other health professionals was all positive about the way staff treated children, young people and those close to them. People gave us examples of when staff kindness had been above and beyond their expectations. They told us how community nursing staff had fundraised by walking up Snowden and written to local businesses and supermarkets to fund a Christmas party for all children on their caseload. Other parents told us how they had made such a different with their kindness and patience to give them time to discuss their child and their concerns.

Staff were highly motivated and inspired to offer care that was kind and promoted the dignity of children and young people. This caring and compassionate approach was embedded into everything staff did and was led by the matron.

The excellent caring and compassion approach demonstrated by children’s community nursing staff was led by the matron and embedded within the service. Parents told us the matron was contactable outside normal working hours to support them and when needed visited them. Staff told us the matron had gone out at midnight to the local hospital (part of the trust) to collect pain relief for an end of life child. We were told they had gone above and beyond insisting the pharmacist came into the hospital to dispense the medicine to keep the child pain free and comfortable. We saw the matron was fully involved in providing both on call support and hands on 24-hour care to an end of life child two out of every three nights. School nurses told us the matron knew most of the children by name and their needs and always put children and their needs first.

We found community children’s nursing staff in all areas and services we visited were kind, patient, caring, compassionate and thoughtful putting the child and their family first. Staff demonstrated in all areas we visited an exemplary empathetic and compassionate approach. The matron told us staff were immensely caring and compassionate to children, young people and their families going beyond usual expectations, frequently staying late to ensure they and their families had excellent care and support. The matron told us staff would stay late and provide overnight
Parents told us the community learning disability nurses treated them and their children with respect. In one special school we observed a pupil wandering in the corridor without a named adult. We saw that the special school nurse demonstrated a very caring, responsible approach to this child until their responsible adult was located.

We saw that staff respected children and families ethnic background and their ethnic cultures and values were central to the care they received.

**Emotional support**

**Children, young people and their families valued their relationship with staff. They felt really cared for and that they and their emotional and social needs mattered.**

Staff built up trusting and often long-term relationship relationships with children, young people and people they were close to by working in an open and supportive way. We observed staff gave excellent support supporting them to care for their children who had complex and challenging needs. We observed staff ask them how they were, how they were managing and provided them additional advice and information to access advice and support.

Children, young people, their families and others close to them emotional and social needs were highly valued by staff and were central in their care and treatment. We consistently saw how community learning disability nurses supported parents, grandparents and families emotionally especially when some children’s behaviour was challenging. Staff listened and provided an opportunity to discuss this behaviour in a safe environment with a non-judgemental approach.

Parents told us how positive the emotional support they received had been and how community nurses had supported them to make referrals to other agencies such as caring for the carers. Parents told us learning disability nurses gave them emotional support, advice and practical assistance.

The matron told us a child with severe learning disability had become unwell and had been admitted to hospital. The child had not coped well and was agitated and distressed with the hospital environment and regime. The learning disability nurse had immediately visited the child in hospital and worked with the nurses to develop a plan of care so staff understood their needs. They provided a special clock so the child could understand time such as ‘their medicines would be in an hour’.

Families told us that the learning disability nurses had helped them make applications to other services for example for funding for soft play materials, applications for short breaks and home support which had been enormous help and gave them time with their other children.

We discussed how staff supported families in the event of a child or young person death. We found arrangements had been thoughtfully and compassionately made to ensure nurses and doctors the family knew well would attend to provide initial bereavement support.

**Understanding and involvement of patients and those close to them**

Children, young people and their loved ones were active partners in care. Staff were committed to working in partnership, ensuring all patients and family members took part in
decision-making. They taught parents and carers to manage their family members’ care where possible, to maintain independence.

We saw that the child, young person and their families were supported and taught to undertake as much of their care as they felt confident to do. The matron told us they taught parents and carers to administer specialist medicines and reinsert specialist breathing and feeding tubes when needed.

One family had requested that their child was nursed at home at the end of their life. We saw a small team of community children’s nurses provided on call 24 hours a day seven days a week providing care and support to child and their family. The team provided continuity of care up until the child’s death the small team were each on call visiting throughout the night when required two out of every three nights in addition to undertaking their usual day time shifts. The staff motivation to do the right thing for the child and their family was outstanding.

One young person we spoke with told us that the nurses don’t just do tasks but went out of their way to make time to chat and they loved to chat.

We saw that learning disability nurses asked parents about the effects of treatment, sleep patterns and eating habits and fully engaged both with parent(s) and young people in these conversations and could give information parents were able to understand. They asked parents for their thoughts and agreement to refer to other services such as to a psychiatrist. We saw they asked parents for their views about possible referral to other services such as to a psychiatrist.

We were told about a young person who had body image challenges and found it difficult to attend medical appointments. The learning disability nurses had not only worked with them to increase their confidence in relation to their body image also accompanied them to the hospital appointment and follow up appointment.

One parent told us the learning disability nurse had fully involved them with behaviour modification management and as a result their child was much less aggressive and no longer hit them.

Parents told us that the learning disability nurses explained everything and gave them information to support them. They told us they were fully involved in every decision about their child’s care and were offered choices about other care opportunities.

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**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

Services were provided in a way that met the needs of children, young people and their families.

There were service specification agreements in place with commissioners for children’s community nursing service including learning disability nurses and special school nursing which had recently been reviewed and updated.

Referrals to the community nursing service were accepted for any child or young person who attended a special school within Solihull Borough or had a Solihull GP. We were told that occasionally a referral would be accepted as a reciprocal agreement with another local trust if the child lived within Solihull but did not have a Solihull GP. The service was notified of all children within Solihull Special schools by the Head Teachers for special school nurses and community paediatrician or when appropriate by the learning disability team or the community nursing team.

The service then contacted the family and either arranged a home visit or a meeting within school to discuss their health needs and become part of the special school nursing caseload.
Parents, health professionals and other agencies could make telephone referrals for community children’s nursing care direct to the office number identified on the trust website. All parents we spoke with reported no problems accessing the services and said they had a same day response with either a telephone call or a visit.

Visits were planned and arranged according to the needs of the children for example children requiring ongoing oncology care had at least weekly visits whilst treatment visits may be daily for four consecutive days dependent on the treatment.

The service was 8.00 till 6.30 pm Monday till Fridays and 9-1pm on a Saturday. Staff told us and we saw during our inspection that the community children’s team provided a 24-hour service to provide care for an end of life child or young person to support them and their family.

Learning disability nurses contacted each special school weekly to discuss difficulties the children may have and treatment strategies.

The learning disability nurses provided five workshops sessions for parents annually at each special school. The workshops provided support and advice for parents and discussed problems such as behaviour, toileting and sleep. We were told responsive sessions could also be arranged if several children and parents were experiencing a particularly problem.

The learning disability nurse provided training for health and education staff as part of the ‘Solihull Approach’ which included family support and hospital passports.

The service had recently employed an attention deficit/hyperactivity disorder (ADHD) nurse. Whilst the funding for this post had been temporary for 12 months by another organisation the service was positive about continuing with this post. The matron and consultants were positive about the impact this would have for the care, treatment, review and support for children and families with ADHD. The ADHD nurse will hold nurse led clinics in the community.

Staff working in special school told us they had regular sessions within the schools with speech and language therapists, physiotherapists, community paediatricians and community children’s nurses would also come to the school to take blood when required. This meant that the children and young people were in a place they were familiar with and they and their parents did not have to travel.

The community paediatricians were included in the on-call rota covering the sexual assault referral centre.

**Meeting the needs of people in vulnerable circumstances**

The service took account of and was responsive to the individual needs of children, young people and their families.

Parents, education staff and other health professionals told us how responsive the community children’s service was. One member of education staff told us they could easily contact the special school nurse when needed. They told us they had one pupil who had pulled out their ‘button’ for specialist feeding tube. The school nurse had promptly visited and replaced the ‘button’ which had avoided having to send the pupil home.

The community paediatricians provided a range of services supporting general practitioners, health visitors and special schools. Two of the community paediatricians were on the sexual assault referral centre on call list. This access to a consultant who specialised in the care and treatment was invaluable for children and young people.

The learning disability nurses had regular contact and provided support to special schools. They received referrals for advice mostly to support with behavioural problems and attended parents
evening. They provided several workshops annually for parents of children in each of the four special schools within Solihull Borough to discuss toileting, personal relationships, puberty and other behaviours that may challenge them.

A health passport is considered best practice particularly for children and young people with a learning disability should they go into hospital or move to another healthcare setting. The health passport identifies essential and valuable information about the person’s needs including medicines, allergies, special adjustments alongside their likes and dislikes and preferred communication. We found one of the seven care records contained a health passport.

We observed the learning disability nurse demonstrated good understanding of family’s ethnic values. They asked appropriate questions about their lifestyle to reflect their ethnic diversity.

Staff told us that they could access translation either by phone or in person dependent on need.

Learning disability nurses provided information in easy read and pictorial format to meet the needs of children, young people. For example, we information given about using ‘kind words’ in pictorial format when parents said their children had been unkind and nasty to each other.

We saw that parents were given an information leaflet about the learning disability service although it did not accurately reflect current service provision.

**Access to the right care at the right time**

Most children and young people had timely access to services. However, the referral to treatment wait for the special assessment service, autism service and occupational therapy service had consistently exceeded the required waiting time and were not in line with good practice.

The community children’s service had key performance indicators for routine referrals to the service. the child should be seen within seven days and for palliative care the child or young person should be seen within 48 hours. Parents and carers told us the service was very responsive and mostly they would receive a visit the same day. Information provided by the trust identified from April 2018 100% of urgent referrals were seen within 48 hours and 100% of non-urgent referrals were seen within seven working days.

The National Institute for Health and Care Excellence best practice for attention deficit/hyperactivity disorder (ADHD) identifies children or young people should be seen within 10 weeks of referral. The current waiting time for this service is 20 weeks. However, staff were confident the availability of the ADHD nurse should ensure more children were seen earlier.

Staff told us that there were 17 children on the waiting list for the learning disability service. The longest wait was 18 weeks with a recent breach to the 18 weeks wait, staff also told us two children were due to breach the 18 weeks wait. Staff told us children referred for treatment were triaged to determine the urgency of treatment.

**Accessibility**

The trust has not supplied percentages or numbers around the largest ethnicity group within their catchment area but has ranked them from first to fourth highest.

<table>
<thead>
<tr>
<th></th>
<th>Queen Elizabeth Hospital</th>
<th>Birmingham Heartlands, Good Hope and Solihull Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White British</td>
<td>Pakistani</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian (Indian, Pakistani, Bangladesh)</td>
<td>Indian</td>
</tr>
<tr>
<td>Third largest</td>
<td>African Caribbean</td>
<td>Caribbean</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian (Chinese, Philippines)</td>
<td>Bangladeshi</td>
</tr>
</tbody>
</table>
Referrals

The lead consultant told us that there was currently an eight month wait for special assessment service (assessment and treatment of children and young people for autistic spectrum disorders). Information below identifies the number of children seen within 18 weeks of being referred to the service had decreased and children and young people were waiting longer to be seen.

<table>
<thead>
<tr>
<th>Month</th>
<th>Service</th>
<th>0-17 Weeks (numerator)</th>
<th>18-51 Weeks</th>
<th>52+ Weeks</th>
<th>Total on Waiting List (Denominator)</th>
<th>% waiting under 18 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-17</td>
<td>Specialist Assessment Service</td>
<td>147</td>
<td>65</td>
<td>0</td>
<td>212</td>
<td>69.34%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>Specialist Assessment Service</td>
<td>119</td>
<td>112</td>
<td>0</td>
<td>231</td>
<td>51.52%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>Specialist Assessment Service</td>
<td>156</td>
<td>103</td>
<td>0</td>
<td>259</td>
<td>60.23%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>Specialist Assessment Service</td>
<td>182</td>
<td>95</td>
<td>0</td>
<td>277</td>
<td>65.70%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>Specialist Assessment Service</td>
<td>216</td>
<td>114</td>
<td>0</td>
<td>330</td>
<td>65.45%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>Specialist Assessment Service</td>
<td>143</td>
<td>139</td>
<td>0</td>
<td>282</td>
<td>50.71%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>Specialist Assessment Service</td>
<td>73</td>
<td>162</td>
<td>0</td>
<td>235</td>
<td>31.06%</td>
</tr>
<tr>
<td>May-18</td>
<td>Specialist Assessment Service</td>
<td>45</td>
<td>168</td>
<td>0</td>
<td>213</td>
<td>21.13%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>Specialist Assessment Service</td>
<td>15</td>
<td>173</td>
<td>0</td>
<td>188</td>
<td>7.98%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>Specialist Assessment Service</td>
<td>6</td>
<td>171</td>
<td>0</td>
<td>177</td>
<td>3.39%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>Specialist Assessment Service</td>
<td>1</td>
<td>155</td>
<td>0</td>
<td>156</td>
<td>0.64%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>Specialist Assessment Service</td>
<td>1</td>
<td>133</td>
<td>0</td>
<td>134</td>
<td>0.75%</td>
</tr>
</tbody>
</table>

The trust has identified the below services in the table as measured on ‘referral to initial assessment’ and ‘assessment to treatment’.

The trust met the referral to assessment target for six of the eight services listed. The performance of the paediatric occupational therapy unit was notably below the national average.
### Is the service well-led?

#### Leadership

Managers within children’s community service had the right skills and abilities to provide the service. However, there was a need for greater insight and engagement from more senior managers within the trust to ensure safe, high-quality and sustainable care is provided.
Community children’s and young people’s service was within Division 2 of the University Hospital of Birmingham and had previously been part of the Heart of England NHS Trust. The allied health professionals who worked with children in the community was within division 4. Each division had a divisional hospital director and a divisional director of operations.

The community children’s team was part of group b Division 2 with direct managerial responsibility of the director of operations. Group b support management team was led by a group manager, a group support manager and a clinical lead. The community children’s allied health professionals were within group b of division 4 with a similar group support management team to division 2 but also had a therapies clinical lead.

The acquisition of HEFT to form with University Hospitals Birmingham had been recent. Staff consistently told us they did not feel part of the trust and ‘just got on with providing services to children’. One doctor we spoke with said they felt ‘peripheral’ since the change to University Hospitals Birmingham.

Staff told us the matron was accessible and supportive but were unclear of the management structure above the matron. Staff said they did not feel connected to, or engaged with by either senior managers or other teams within the trust outside the community children’s service.

The matron for community children had been in post since June 2018 and was previously a team leader for the community children’s service. The matron managed the three community children’s and young people’s services: community children’s nursing, special school nursing and community learning disability nursing and managed the paediatric clinical nurse specialists at Heartlands Hospital.

The learning disability nurses told us they had approachable local managers who were “so so supportive” and with whom they could raise concerns.

There was a consultant community paediatrician who was the clinical lead doctor for the service. We saw no formal engagement between the community paediatricians and the medical lead for paediatrics within the trust.

There was no identified time for the community safeguarding lead doctor as required to ensure effective and appropriate management of safeguarding.

**Vision and strategy**

The trust had an identified vision but clear plans were not in place to identify how the community children’s and young people’s services should to deliver it.

The trust’s vision was building healthier lives and this was the logo on trust information. Whilst we saw this vision was central to the work undertaken by community children and young people’s staff there was no clear and coordinated strategy for the delivery of this.

Whilst service specifications were in place and agreed with commissioners for children’s community nursing and special school nursing there was no identified medium and long-term strategy for children’s community services. The lead paediatrician told us there had been no overall strategic review of community paediatric services since 1991.

The community nursing service provided 24-hour care seven days a week for children and young people who were at the end of their life. However, there were no contingency support arrangements including highlighting potential risks, such as the length of time the team needed to provide cover, arrangements to cover illness or should there be more than one child and family that required this level of input from the team.
The service was small and several teams had four or fewer staff (paediatric consultants, learning disability nurses, ADHD). We found there had been no strategy to identify succession plans such as when the current consultants retire or leave or long-term absence.

**Culture**

*Managers within the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, staff did not feel their service was understood or valued by others outside the service.*

Staff spoke positively about the children’s community services, teamworking and support they received from the matron and others within the service. They said they were proud to work for the service.

The matron spoke positively about their team, “I have a great team and I’m very proud of the care they provide”.

Special school nurses reported managers had an open-door policy and they could go to them with any concerns. Special school nurses spoke positively about the matron whom they said knew most of the children, their needs and challenges. However, staff said that more senior managers within the trust were more focused on acute services than the paediatric community services.

Staff in special schools said they had a great service and helped children stay in school. A headteacher told us they had excellent relationships with the special school nurse, they worked well as a team, had the child as their focus to care and the community matron was accessible.

Staff were aware of duty of candour and the importance of highlighting when things went wrong. The matron told us about problems they had with ventilation tubes which had needed to be replaced. They told us they had highlighted this with the trust and the split tubes had been returned to the manufacturer for further investigation. They had informed the child’s parents of what they had done and was being investigated.

The service had appropriate lone arrangements in place to keep the staff safe. Staff were aware of the trusts lone working policy. Staff told us that whenever possible they worked in pairs but if this was not possible they were arrangements in place to ensure other staff had their contact details, knew their patient visit plan with addresses and would call to say when the visit had been completed. Staff told us there were plans in place for them to carry tracker devices to alert others when needed.

**Governance**

*The arrangements for governance and performance management do not always operate effectively.*

There was an identified governance structure but it was not clear all levels of governance management function operated effectively. Whilst the community children and young people’s service was a relatively small it was not clear from information provided by the trust that the arrangements for or performance of the community children and young people’s service was regularly discussed at divisional or quality and safety meetings. We were not assured information about the service such as staffing, risks and performance were effectively cascaded up to the senior management team or downwards to clinicians and other front-line staff.

**Management of risk, issues and performance**
There were systems in place to identify risk but they were not consistently used. This meant senior managers may not be fully sighted about the risk or appropriate plans in place to eliminate risk.

Children’s community services were within two divisions; division 2 women and children’s services and division 4 medicine (which included community therapies). Risks regarding children and young people’s services may be included in either risk register. There were no risks relating to community children’s service on the risk register for women and children’s services. We saw community children and young people’s therapy service had an identified risk: breach of the waiting list target for community children’s therapy services.

There were monthly paediatric quality and safety meetings (Division 4) in which community paediatric therapists were part of. We saw the meetings reviewed incidents, identified risks, safety alerts, safeguarding and patient feedback. There were plans identified to minimise risks and improve performance. We saw following an identified risk the service had plans in place to recruit additional occupational therapists and therapists for the special assessment service due to increased patient referrals and long waiting times to be seen following referral. However, the quality and safety meetings for division 2 had no information about community children’s services risks and performance issues we identified such as learning disability staffing, the split ventilation tubes, waiting time for the autism service and succession planning for the service.

We saw there were sub division meetings which reviewed community paediatric therapy services and risks were escalated to the senior management team. The group manager (group a division 2) told us they did not have performance meetings within the group but met regularly with the matron staff to discuss the service. We saw no evidence that information and risks and performance shared within these was escalated to the senior division management team or the senior management team were aware of challenges the service had. Senior staff told us they struggled to escalate this information and did not feel their voices were heard.

The matron had recently developed a matrix that includes performance indicators from each children’s community nursing service with a quality improvement plan that was updated monthly and shared with senior managers.

There were regular and usually monthly band 6 six meetings and team meetings within all services. These meeting identified changes in practice, patient feedback, incidents, staffing arrangements including lone working and performance for example the staffing challenges within the learning disability team.

Information management

Information was collected, analysed, managed and used to support its activities.

The matron completed a monthly report which included patient feedback, staffing, vacancies, incidents complaints which was then sent to senior managers as an overview of the service. Whilst we saw senior managers were supportive it was unclear where and how feedback on performance was shared more widely and when needed acted upon.

The service utilised information technology and electronic patient records. We saw technology access was password protected.

We saw information to show the use of technology had been effective in the identification of patient’s outcomes and when improvements should be made.

The service was part of the West Midlands Children’s Palliative Care Network. The network provided information about children’s palliative care management and services within the West Midlands.
Engagement

The service engaged well with children and their parents and carers, staff and other organisations to manage services.

Staff told us they had weekly newsletters although they were focused on the acute services. The service used patient satisfaction surveys which were sent out when they had been receiving the service for three months and thereafter every 12 months. The community nursing team had developed post cards that were given to parents as a quick feedback about the service. The children’s community team told us they were also looking at how they could also receive feedback by text message.

The special assessment service sought comments and feedback from children and young people who used the service. Feedback could be made into post boxes which had a good, ok, or bad label to summarise ‘how was your time here today?’ Children and young people could also put comments onto ‘leaves’ on the comments tree which was in the waiting area.

The learning disability nurses service identified that parents and carers frequently had little time to complete patient’s surveys. The nurses had responding to this by giving out postcards on which children, young people and their parents or carers could provide a short feedback on the service it received.

The matron told us they had a good relationship with commissioners and had been able to identify a need for additional funding in response and providing an improved service for children.

Education staff within special schools said the matron was accessible, responsive and supportive to developments within specials school.

Learning, continuous improvement and innovation

The service and its staff were committed to improving and developing services and learning when things go well.

Staff were motivated to make improvement and provide excellent and compassionate care for children and young people. We saw positive improvements made with the appointment of the ADHD nurse with the support provided to children and their families living with ADHD.
Community health services end of life care

Facts and data about this service

University Hospitals Birmingham NHS Foundation Trust acquired Heart of England NHS Foundation Trust on 1 April 2018 under its existing registration with the CQC. As such, our legal position is that the provider still exists but with added locations.

We have included data from the pre-acquisition period for University Hospitals Birmingham NHS Foundation Trust. Because it related to the same legal entity we have used this to form part of our judgement.

Where we have included data from the acquired Heart of England NHS Foundation Trust (due to no new data being available), we only provided this for contextual purposes and it did not form part of our judgement. For example, whilst some national audit findings relate to a previous legal entity we expected the trust to be able to demonstrate how they responded to the data to improve services.

University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust underwent an acquisition in April 2018, therefore all national datasets contained within this appendix relate to this period onwards.

Information about the sites and teams, which offer community health services for end of life care at this trust, is shown below:

<table>
<thead>
<tr>
<th>Location / site name</th>
<th>Team/ward/satellite name</th>
<th>Services provided</th>
<th>Address (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marie Curie Hospice</td>
<td>Palliative care team</td>
<td>Specialist palliative care</td>
<td>Marie Curie Hospice, Marsh Lane, Solihull B91 2PQ</td>
</tr>
</tbody>
</table>

The service aims to provide specialist palliative care for adults who have advanced progressive illness and those with complex specialist palliative care needs as well as providing leadership and support to community teams providing generalist palliative care.

Specialist support includes a telephone triage service, holistic assessment and care planning, provision of information on disease process, treatment, medication, local and national services, symptom control; spiritual and psychological support for patient/carer, non-medical prescribing and bereavement support.

Palliative and end of life care was an integrated service provided by community nurses with the support of a dedicated specialist palliative care team (SPCT) employed by the trust. Throughout this report we refer to the community adults team and specialist palliative care team, however we did not inspect community adult services at this inspection.
Mandatory training

Mandatory training completion rates

A breakdown of compliance for mandatory training courses from April 2017 to March 2018 for qualified nursing staff in community services for end of life care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>April 2017 to March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>9</td>
</tr>
<tr>
<td>Resuscitation - clinical</td>
<td>9</td>
</tr>
<tr>
<td>Major incident awareness</td>
<td>9</td>
</tr>
<tr>
<td>Corporate induction</td>
<td>9</td>
</tr>
<tr>
<td>Waste Management</td>
<td>9</td>
</tr>
<tr>
<td>Information governance</td>
<td>9</td>
</tr>
<tr>
<td>Infection prevention and control</td>
<td>8</td>
</tr>
<tr>
<td>Medicines management</td>
<td>9</td>
</tr>
<tr>
<td>Manual handling - patient handling</td>
<td>9</td>
</tr>
<tr>
<td>Equality &amp; diversity</td>
<td>9</td>
</tr>
<tr>
<td>Fire safety</td>
<td>9</td>
</tr>
<tr>
<td>Health &amp; safety</td>
<td>9</td>
</tr>
</tbody>
</table>

In community services for end of life care, the trust had an overall training compliance rate of 100.0% for qualified nursing staff. The trust’s 90% completion target was met for all 12 mandatory training modules for which qualified nursing staff were eligible.

Palliative and end of life care was provided jointly by the community nurses and the specialist palliative care team (SPCT) employed by the trust.

The trust used an electronic monitoring system to manage staff mandatory training on a yearly basis. Subjects included in the programme were safeguarding, infection control and manual handling. Staff told us they were responsible for making sure that they were up to date with all their training and could access their training records online. Staff were sent reminder emails when their training was due to expire.

There were no end of life care modules on the mandatory training programme. However, the trust informed us after our inspection that all community nursing staff had received two days training delivered by the specialist palliative care team. The trust had not set any targets for this training as it was not classed as mandatory.

Safeguarding
Staff who provided end of life care said they had received mandatory training in safeguarding children and vulnerable adults. Safeguarding training was part of the trust’s mandatory training programme.

Staff had a good understanding of how to protect patients from abuse and could describe what safeguarding was and the process to refer alerts.

The specialist palliative care team (SPCT) were up to date with their adult and children safeguarding training. Data showed the that 100% of the SPCT and the community nurses were trained to level three safeguarding, which is essential level of training required for the team, against the trust target of 90%.

Staff had a good understanding of how to protect patients from abuse and could describe what safeguarding was and the process to refer alerts. For example, one staff member told us of a referral they had made to the safeguarding team concerning the alleged neglect of an end of life care patient.

Staff were aware of the trusts whistleblowing procedures and what action to take if they had concerns.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community health services for end of life care made no safeguarding referrals for adults or children between April 2017 and March 2018.

**Cleanliness, infection control and hygiene**

Overall, we found the standards of cleanliness and hygiene were good and staff demonstrated a good knowledge of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and the prevention of healthcare acquired infection.

The service had an up-to-date infection control policy, which provided guidance for staff on the prevention and control of infection. Risks associated with the prevention and control of infection following the death of a patient were contained in the provider’s infection prevention guidelines.

Throughout end of life care, we observed staff to be complying with best practice about infection prevention and control policies. Staff were observed to wash their hands or use hand sanitising gel between patient contact. There was access to hand washing facilities in the hospice. Personal protective equipment, which included gloves and aprons, were readily available. All staff were observed to be adhering to the organisation dress code, which was to be ‘bare below elbows’. Patients commented that all staff washed their hands before and after treatments.

Staff undertaking community visits had adequate supplies of gel hand sanitiser and personal protective equipment (PPE).

All the clinics we visited were visibly clean. Gel dispensers and hand washing facilities were available in all clinical areas and staff working in the community carried hand gel with them. There were public reminders for patients to wash their hands.
Staff working remotely also had access to cleansing wipes. They used these to clean items that may be contaminated. Personal protective equipment such as gloves and aprons were readily available.

**Environment and equipment**

Specialist equipment needed to provide care and treatment to patients in their home was appropriate and fit for purpose, which meant patients were protected from avoidable harm. Equipment was accessed through a local community equipment service. None of the staff we spoke with raised any concerns with accessing equipment and told us equipment could arrive in the patient’s home the same day.

The service used syringe pumps for end of life patients requiring a continuous infusion to control their pain. A continuous infusion is a controlled method of administering intravenous medicines without interruption. Syringe pump equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from avoidable harm when a syringe driver was used to administer a continuous infusion of medication; as the syringe drivers used were tamperproof and had the recommended alarm features.

Staff provided appropriate equipment to support patients’ health and wellbeing. For example, we saw staff discussing equipment needs with patients such as specialist beds and chairs.

There were suitable arrangements for the segregation of and disposal of clinical waste. We saw appropriate clinical waste containers in use.

All locations we inspected had good security in place. The clinics and services were provided remotely from trust premises.

**Assessing and responding to patient risk**

Community end of life and palliative care took place in patients own homes or at the local hospice. Community nurses, the specialist palliative care team and other members of the multidisciplinary team (MDT) had regular meetings to discuss patients, their requirements and any risks that had been identified.

Community nursing teams and the SPCT were well placed within the localities they served. Each team had a lead for end of life care and there was a specialist palliative care nurse allocated to each geographical community nursing team. There was routine engagement by the teams providing community end of life care with other partners such as GP’s and the local hospice. This meant staff were kept informed and could make arrangements for patients that were awaiting referral for end of life care services.

Comprehensive risk assessments were carried out for patients and risk management plans developed in line with national guidance. We reviewed the care records of seven patients identified as being either palliative or at the end of life. We identified the following risk assessments being used; a Walsall assessment for pressure ulcers, malnutrition advisory score (MAG) and falls assessment. We noted that these risk assessments were regularly reviewed where appropriate. We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.

Specialist palliative care nurses were available from 8.30 – 4.30 Monday to Friday. However, there was no on call specialist palliative nursing cover out of hours except for one nurse at weekends. Out of hours cover was provided by two whole time equivalent (WTE) consultant posts based at and paid for by the local hospice but employed by the trust. Consultant cover was provided Monday to Friday 9am to 5pm. Out of hours and emergency cover was provided by an on-call consultant who was contactable by phone. All other out of hours cover was provided by the local G.P. service.
The service had a fast track referral pathway. This pathway helped clinicians make a decision to fast track a patient for NHS Continuing Healthcare, on the basis of need, due to a rapidly deteriorating condition which might be entering a terminal phase. We did not see any patients undergoing this fast track system during our inspection.

**Staffing**

Although the trust has supplied data relating to community staffing numbers, the trust has not included data pertaining to end of life care.

The SPCT reviewed the records of their patients daily to gain information on the patient’s condition. The SPCT and community nursing teams each had a lead for end of life care.

We saw evidence, when attending a handover meeting that the community nursing teams were reviewing records of patients who were at the end of life. Patients were triaged and assessed accurately so that safe treatment and care was provided to guard against risks associated with their condition.

Both the community nursing and SPCT team completed daily handovers either in person or by telephone with the night team so that the transfer of care between the teams was smooth and seamless. These were then updated on the community electronic system. This meant that relatives of patients did not have to repeat issues to the different teams.

There were systems in place to ensure that staff, equipment and facilities enabled the effective delivery of care and treatment. The specialist palliative care team (SPCT) was employed by the trust but based at the local hospice. End of life care was therefore undertaken by both the SPCT and the community nursing teams. End of life and palliative care patients were included within the case load of the community nurses.

During our inspection, the specialist palliative care team lead told us the SPCT consisted of just under eight whole time equivalent (WTE) band seven nurses and was fully staffed. One member of the team was on long term leave; however, their shifts were covered by an agency nurse.

Community nurses told us during our inspection there were several vacancies, and it was very difficult to recruit to the positions. We requested from the trust a breakdown of the vacancy rates for community nurses who provided end of life care, however, we did not receive this information. Instead the trust sent us the medicine directorate risk register which had an entry for the community nurses stating the trust were unable to continue to provide a safe District Nursing Service due to increased demand and decreased capacity. We could not see any actions in place to mitigate this.

There were two WTE consultant posts based at and paid for by the local hospice but employed by the trust. Consultant cover was provided Monday to Friday 9am to 5pm. Out of hours cover was provided by an on-call consultant who was contactable by phone. All other out of hours cover was provided by the local G.P. service.

We requested from the trust a breakdown of the turnover rates in end of life care, however, we did not receive this information. Turnover rates for medical staff and nursing were reported within the individual directorates.

We requested from the trust a breakdown of the sickness rates in end of life care, however, we did not receive this information. Sickness rates for medical staff and nursing were reported within the individual directorates.
We requested from the trust a breakdown of bank and agency qualified nurses in end of life care, however, we did not receive this information. Bank and agency qualified nursing rates for medical staff and nursing were reported within the individual directorates.

We requested from the trust a breakdown of bank and agency non-qualified nurses in end of life care, however, we did not receive this information. Bank and agency non-qualified nursing rates for medical staff and nursing were reported within the individual directorates.

We requested from the trust a breakdown of medical locums in end of life care, however, we did not receive this information. Medical locum rates were therefore reported within the individual directorates.

**Quality of records**

The service had a centralised, computerised patient co-ordination system. This was a patient register, which could be accessed by primary care services in the community such as GPs, district nurses, and hospice at home teams, as well the community nurses and the SPCT.

The community nursing services had access to the information stored within the electronic care records. This meant staff could recognise patients within end of life services and access the appropriate care promptly.

Patient hand held records were paper based in the patient’s home and electronically in the work place. This meant staff were undertaking a duplication of work. We reviewed seven complete sets of patient records (including nursing risk assessments, care plans and observation charts) and found they were all legible, contemporaneous, signed and dated and contained specific details about patient care. Nursing risk assessments and care plans were individualised and were updated on a regular basis or when changes in the patient’s condition was noted.

The service did not use EPACCS (Electronic palliative care coordination system). Care was coordinated through an electronic computerised system that provided clinicians and health professionals with a single shared electronic health record (EHR) available at the point of care. A special note was placed on the patient’s electronic care record to denote they were either palliative or end of life.

Letters and care plans were sent electronically through secure email to patients and families or by post.

**Medicines**

Medicines were regularly reviewed as part of daily handovers, multidisciplinary team meetings and the Gold Standard Framework (GSF) meetings. GP’s or non-medical prescribers wrote prescriptions for controlled drugs for care givers to collect from the local pharmacy. These were administered by community and the specialist palliative care nurses.

We found controlled drugs were managed in accordance with the Controlled Drugs Regulations 2013. Controlled Drugs are a prescription medication that is controlled under the Misuse of Drugs legislation. They are classified (by law) based on their benefit when used in medical treatment and their harm if misused.

There were appropriate systems in place to protect patients against the risks associated with the unsafe use and management of medicines. Staff followed clear guidelines for prescribing medicines. We looked at seven risk assessments for palliative care patients and found all had been completed appropriately. For example, on a home visit where a syringe pump was being continually used we saw a risk assessment identifying a locked box was not needed for the equipment as there were no adverse risks identified in the household.
Medication was stored in pharmacy bags at patients’ home. We reviewed medication charts and saw that nurses checked the stock levels on every administration as well as expiry dates and the dose of medication.

On one home visit, we saw a prescription for extra medication for breakthrough pain PRN (as and when required). We saw this was monitored, regularly reviewed and recorded appropriately.

We saw documentation and observed care that followed the Nursing and Midwifery Council standards for medicine management. This meant that patients were protected against the risks associated with the unsafe use and management of medicines.

There were two members of the specialist palliative care team (SPCT) were non-medical prescribers and five non-medical prescribers in the community nursing teams. Non-medical prescribing, is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional’s field of expertise. One of the community nurses we spoke with said she would shortly be undertaken her non-medical prescribing course.

The service worked to the protocol ‘The five priorities for end of life care.’ The protocol was for the last 48 hours of life and provided guidelines for staff on actions to take such as anticipatory prescribing.

Anticipatory medicines for patients were prescribed for the five key symptoms in the dying phase. These symptoms are pain, agitation, excessive respiratory secretions, nausea and vomiting, and breathlessness. By prescribing medicines, ‘just in case’, before the patient has any symptoms, this allowed patients to receive effective symptom control in a timely manner.

We checked seven medication administration records and found that all the records demonstrated anticipatory prescribing was undertaken to reduce the risk of escalating symptoms. We also spoke with seven patients, all of them said their medication had been explained to them by the community nursing team.

Duty of Candour training was not part of mandatory training. All the staff we spoke with were knowledgeable about the Duty of Candour, however, nobody could remember an event where this had been required. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Incident reporting, learning and improvement

Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to July 2018, the trust reported no never events in community health services for end of life care.

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).
From April 2018 to July 2018, the trust reported no incidents in community health services for end of life care.

**Serious Incidents (SIRI) – Trust data**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community health services for end of life care, which met the reporting criteria, set by NHS England between April 2017 to March 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Staff reported incidents through the trust’s electronic reporting system. Community nursing staff and the SPCT understood their responsibilities to raise concerns and report incidents and near misses.

Staff were familiar with the systems that were in place to ensure that incidents were reported, investigated and learnt from. Staff told us that incidents and significant events were discussed at team meetings, training sessions and clinical governance meetings.

Incidents were reported through an electronic reporting system. Discussions with staff demonstrated a good awareness of the incident reporting policy and how to use the reporting system. Any serious incidents would be investigated through the use of root cause analysis and where necessary further training would be arranged.

Mortality and morbidity meetings took place monthly. This supported the trusts learning from the deaths review process.

Duty of candour was not part of mandatory training, however, all staff we spoke with had a good understanding about duty of candour. Staff talked of being open and honest when things went wrong. Staff were not able to give example of where duty of candour had been applied, as they could not remember a time when an incident had occurred requiring a response under duty of candour. Senior leaders were aware of duty of candour process and the requirement to send formal apology letters to patient and families when a patient had encountered moderate or above harm.

**Is the service effective?**

**Evidence-based care and treatment**

The trust did not have an end of life care strategy or vision that included prioritised and timebound actions with appropriately allocated leads. However, they were adopting the principles of National end of Life Care strategy 2008. For example, asking patients their choice of where they wanted to be cared for, monitoring symptoms and asking about advanced decisions.

The trust did not audit patients preferred place of care or death for community end of life care patients or participate in any national audits or benchmarking exercises apart from the National Minimum data set which ceased in 2017. This meant patient outcomes were not regularly monitored and reviewed to ensure the end of life care service were meeting the needs of patients.

The trust took part in the Gold Standards Framework (GSF). This is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It enables frontline staff to provide a gold standard of care for people nearing the end of their life.
As part of our inspection, we attended a GSF meeting which included discussions about palliative care patients and patients at the end of their life.

We saw evidence of holistic assessments being undertaken as part of patients individualised last days of life care plan. Treatment and support were delivered in line with legislation, standards and evidence based guidance, including the National Institute of Health and Care Excellence (NICE).

The trust had guidelines policies and procedures that were up to date and accessible to staff on the trusts electronic intranet based on current guidance relating to end of life care. Equality and diversity training was part of the mandatory training programme, this was also easily accessible through the staff intranet. New policies and procedures were communicated to staff through staff meetings, emails and weekly updates.

End of life care was mainly managed and delivered in line with NICE guidance NG31. There was an emphasis on the early identification of people approaching the end of their life in order that discussions around end of life could take place.

The service were using ReSPECT. This is a process that creates personalised recommendations for a patient’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. The plan is created through conversations between a person and their health professionals. The plan is recorded on a form and included in their personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome they would want, that would not help, or that they would not want. However, we found the service were only using the Do not resuscitate in the event of cardiac or respiratory arrest (DNACPR) section of ReSPECT and not the complete paperwork. The rest of the advanced care planning was undertaken on standardised paperwork. Plans to incorporate the rest of the ReSPECT paperwork were being considered for future planning.

Nutrition and hydration

We saw the malnutrition universal screening tool (MUST) being used. This is a universal five-step tool to identify adults who are malnourished, at risk of malnutrition or obese. It also included management guidelines, which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers.

Pain relief

Patient’s symptoms were managed and medication was prescribed for anticipatory medicines (Medication that patients may need to take to make them more comfortable). Advice concerning pain and symptom management was available to staff from specialist staff at the Hospice.

Patients within end of life care had their pain control reviewed daily or more often as was needed. Regular analgesia was prescribed in addition to ‘when required medication’ (PRN), which was prescribed to manage any breakthrough pain. This pain occurs in between regular, planned pain relief.

Pain relief was reviewed for effectiveness and changes were made as appropriate to meet the needs of individual patients. The community teams used a pain tool to assess patients’ level of pain. We also observed staff ask patients whether they were experiencing any pain as well as exploring the type of pain.
Patients told us staff had discussed pain relief with them and they understood what they were taking and the effect the medicine would have.

Staff confirmed syringe pumps were accessible if a patient was receiving end of life care and required subcutaneous medication for pain relief.

Two members of the specialist palliative care team (SPCT) were non-medical prescribers. Non-medical prescribing, is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional’s field of expertise

**Patient outcomes**

The trust has participated in the National Clinical Audit and Patient Outcome Programme (NCAPOP) for community end of life care. The trust has participated in several trust wide audits.

The patients and relatives we spoke with indicated they were happy with the services provided

Care was coordinated through an electronic computerised system that provided clinicians and health professionals with a single shared electronic health record (EHR) available at the point of care.

Audit information demonstrated a low number of audits were completed. The trust explained they were currently reviewing audits moving forward as part of wider end of life development work in the community.

During our inspection we found the trust did not have a process for identifying non-cancer patients requiring end of life or palliative care support. This meant they were unable to identify the percentage of non-cancer patients treated and the percentage of cancer patients treated for palliative and or end of life care.

During our inspection we found trust did not participate in the National Care of the Dying audit for community end of life care. The trust did not audit patients preferred place of care or death for community end of life care patients or participate in any national audits or benchmarking exercises apart from the National Minimum data set which ceased in 2017. This meant patient outcomes were not regularly monitored and reviewed to ensure the end of life care service were meeting the needs of patients

**Competent staff**

The trust reported that they do not hold specific numeric data around individual clinical supervision and do not have specific clinical supervision target. All employees have access to formal managerial supervision. Performance is reviewed in line with the Appraisal Policy and Procedure.

Community nurses received specialist clinical support from the clinical nurse specialists at the local hospice.

A clinical psychologist was based at the hospice to support the SPCT.

Staff received training through e-learning as well as face to face teaching. Staff were positive about the training they received, they told us they had received in-depth training in end of life care from both the hospice and they felt were competent to undertake their work within the service

Discussions with different staff groups identified that clinical supervision was in place in all teams. All staff we spoke with said they had regular appraisals, supervision and safeguarding supervision.

Staff also told us a range of developmental training was available and they had been supported by the trust with their continuing professional development. For example, members of the SPCT
were encouraged to undertake either the Princess Alice course or the palliative care degree.

All members of the SPCT were trained in Advanced Care Planning as part of their mandatory Advanced Communications Skills Training. Community nurses also undertake Advanced Care planning training by the specialist palliative care team.

At the time of our inspection three health care assistants were being developed to be clinical nurse associates. Nursing associates work with healthcare support workers and registered nurses to deliver care for patients and the public. During training, nursing associates are employed in a specific healthcare setting such as an acute, community or mental health hospital, care home or hospice. This training was being undertaken in conjunction with the local university.

**Appraisal rates**

From April 2017 to March 2018, 100% of permanent non-medical staff within the community health services for end of life care core service had received an appraisal compared to the trust target of 85%.

**Community health services for end of life care total**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Required</th>
<th>Completed</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
</tbody>
</table>

Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. All qualified staff in both the community nursing teams and the specialist palliative care team confirmed they had received a meaningful appraisal within the past year.

**Multidisciplinary working and coordinated care pathways**

Staff working with end of life care patients worked closely with external services for example social services, chaplaincy and the local hospice. This allowed staff to provide holistic care and ensure patients received an effective service. We saw the end of life care teams also liaised closely with the nurses, who provided night time care in the community.

Patients receiving end of life care received support from a multi-disciplinary team, which included a specialist palliative care team, (SPCT) consultants, GP’s, social workers, and district nurses. In accordance with the Gold Standards Framework multi-disciplinary team meetings took place weekly to ensure any changes to patients needs could be addressed promptly.

We observed a multidisciplinary meeting, where relevant professionals from both the hospice and the trust were involved in the assessment, planning and delivery of patient care. We observed all patients and their families and care givers were discussed. Discussions included all aspects of pain and symptom control, as well as all aspects of care relevant to the end of life care pathway such as discharge planning and psychological needs.

Staff worked collaboratively with the local hospice, which was regarded as a local centre of excellence for end of life care and care in the last days of life.

In accordance with The Gold Standard Framework, every patient had a named nurse in the community. All patients were visited or contacted at least monthly and information provided about how to contact services.
Health promotion

Staff supported patients who were end of life or palliative to maintain healthy choices and health lifestyles. Information about healthy diets were given to all patients. Staff also told us specialist nurses and other allied health professionals. For example, occupational therapists and dietitians were involved in promoting healthy lifestyles for patients.

In the clinics we saw that nutrition and hydration posters were clearly visible for patients and displayed information on how to undertake a healthy diet.

At one clinic we visited we saw posters for both staff and patients on three-minute seated yoga, sofa workouts and classes on gentle workouts. Additionally, at one G.P practice we saw an automated blood pressure machine in the waiting room for patients to use if they wished to do so.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Patients and relatives told us that staff did not provide any care without first asking their permission. During home visits we observed staff asking for verbal consent before undertaking personal care.

Signed consent forms were evident in all the patient records we examined. This demonstrated that staff obtained consent for treatment appropriately.

Mental Capacity Act (MCA) 2005 training was not delivered as part of the mandatory training programme across the organisation, however, nursing staff were knowledgeable about the processes to follow if a patient was unable to give informed consent to care and treatment. All staff demonstrated a good understanding of consent and capacitated decision making in relation to the Mental Capacity Act. However, we found this was not always documented in patients notes when decisions were being made.

Data showed that community staff were 78% compliant with mental capacity assessment training, against the trust target of 90%.

We visited one patient in the community who we were told lacked capacity by the nurses, however, we were not able to find a mental capacity assessment in the patients notes. We escalated this to the nurse in charge and requested to see the mental capacity assessment for the patient, but were not shown this before the end of our inspection.

The service were using ReSPECT. This is a process that creates personalised recommendations for a patient’s clinical care in a future emergency in which they are unable to make or express choices. However, we found the service were only using the Do not resuscitate in the event of cardiac or respiratory arrest (DNACPR) section of ReSPECT and not the complete paperwork.

The ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) orders were kept at the front of the patients’ medical notes, allowing easy access in an emergency, and were recorded on a standard form. All of the DNACPR orders were easy to read and were transferable to hospital from the community.

During our inspection, we reviewed five DNACPR orders; three of the orders had been appropriately completed in line with national guidance. However, two of the DNACPR orders stated the patient ‘lacked capacity’, but we could not find a mental capacity assessment. We escalated these to the nurse in charge.

The trust did not undertake audits of DNACPR orders or mental capacity assessments for patients in the community. This meant they were not regularly monitored and reviewed to ensure they were correct and meeting the needs of patients.
Deprivation of Liberty Safeguards

From April 2017 to March 2018 the trust reported that 621 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. The trust has not broken down this data by core service, so the above number is the overall number of applications.

The greatest number of DoLS applications were made in January 2018 and March 2018 with 64 applications in each month respectively.

From April 2017 to March 2018 CQC received 624 direct notifications from the trust.

<table>
<thead>
<tr>
<th>Month and year</th>
<th>Number of applications made</th>
<th>Number of applications approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
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<td>7</td>
</tr>
<tr>
<td>May 2017</td>
<td>52</td>
<td>12</td>
</tr>
<tr>
<td>June 2017</td>
<td>50</td>
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<td>January 2018</td>
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<tr>
<td>February 2018</td>
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<td>12</td>
</tr>
<tr>
<td>March 2018</td>
<td>64</td>
<td>17</td>
</tr>
</tbody>
</table>

Is the service caring?

Compassionate care

We observed throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008), that staff spoke about the patients they cared for with compassion, dignity and respect. All the relatives we spoke to told us staff treated their loved ones respectfully and their privacy was maintained.

There was a good person-centred culture. Staff were motivated to offer care which was kind and promoted people’s dignity. Without exception patients and relatives told us staff were extremely kind and caring.

We spoke with the relatives of seven patients who were receiving end of life care. The relatives described the care and support as ‘excellent’ and said they felt ‘well informed’ by staff.

All of the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.

Staff took the time to interact with patients who used services and those close to them in a respectful and considerate manner.

Throughout our inspection and without exception, we observed staff giving non-judgemental care to patients, their families and loved ones.

Emotional support
During home visits, we saw nurses discussed patients’ personal and social interests and provided opportunities to discuss how patients and those close to them could plan for their future and continue to engage in social activities, even when the symptoms of their condition may have restricted them.

All staff considered emotional support as part of their role. Staff completing home visits demonstrated knowledge of patients and their individual situations. Emotional support was tailored to each patient’s and care giver's separate set of circumstances.

Emotional support was also provided to patients and their families through a variety of services, for example the provision of respite care at the local hospice. On one home visit, we saw the community nurse discuss the arrangement of respite care with both the patient and their care giver.

Staff provided and we saw staff explain to patients and their care givers a booklet about end of life called ‘My life’. The booklet covered and we saw staff explaining in a sensitive way a number of different aspects, for example medication, who is involved in my care and lasting power of attorney. Additionally, there were set pages called ‘My personal diary’ for patients to write in. We saw staff encouraging patients to complete the personal diary pages.

**Understanding and involvement of patients and those close to them**

We saw that staff discussed planned care and treatment with patients and relatives.

Patients and family members, we spoke with told us they felt involved in the care delivered. We saw staff discuss care issues with patients and relatives and these were clearly documented in patient’s notes.

One care giver told us “the nurses are like family”. All staff delivered end of life care in a respectful and holistic person-centred way. Staff considered the patients' and care givers individual preferences.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The trust did not have a specific strategy concerning service planning to meet the needs of the local population. They told us This will be included as part of the end of life care and community services strategy development and implementation which was ongoing at the time of our inspection.

Patients were discussed at the weekly specialist palliative care multidisciplinary team meetings and the GSF meetings.

During our inspection we saw general palliative and end of life care was delivered by the community nursing services in partnership with the local hospice, and the specialist palliative care team (SPCT).

The trust worked closely with a local hospice to ensure the end of life care pathway was seamless for patients who required the service. For example, although the SPCT where employed by the trust, they were based at the local hospice. This meant end of life care services for community patients worked together in one hub.
End of life care patients were seen daily as a minimum but sometimes two to three times per day dependent on their nursing and care needs. We saw that each patient had an individual care plan.

Following death, the nurses would make a bereavement visit to the family and loved ones of the deceased. The bereaved were provided with a bereavement pack, which included a comprehensive booklet with practical and emotional support and advice.

District nurses would complete bereavement visits to the families of patients who had died. Counselling services were available at the local hospice.

During our inspection, we observed a number of patient information leaflets available in all the clinics we visited. The leaflets covered a range of issues from infections and illnesses to information about the trust’s complaints procedure in addition to some of which included relaxation techniques, what to expect in the last days of life and information on advanced care planning. The leaflets were available in different font sizes and were presented in a range of languages. There were also cancer care guidelines booklets on health eating readily available.

### Meeting the needs of people in vulnerable circumstances

The SPCT would visit the community staff and patients to deliver specialist advice if needed. There was no specific end of life care pathway for patients with learning disabilities or living with dementia, however, staff told us all end of life care was delivered on an individual and holistic manner so that individual needs were both recognised and assessed.

End of life care services were accessible to all members of the community including vulnerable Patients. Care plans an assessment of emotional and spiritual needs.

Services were delivered, made accessible and coordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.

Staff told us they had good working relations with members of the allied health such as social workers, physiotherapist and occupational therapist and would refer patients to them if needed. Physiotherapy and occupational therapy assessment and treatment was provided at the patients’ home, rather than on hospital wards and included both palliative and end of life care patients.

Patients were approaching the end of their life were supported to make informed choices about their care. This was part of their personalised care plan.

The community nursing teams and SPCT advised patients in a sensitive way of any treatment to be changed or withdrawn and what the processes were. For example, staff told us about one patient who had their medication reviewed to include analgesia for break through pain before they died.

The personalised care plans kept at the patient’s home had a section to record information and the communication needs of people with a disability or sensory loss. This information was also recorded electronically.

All staff had training in equality and diversity as part of their induction and mandatory training. Guidance was available on the intranet to support staff in providing care in accordance with peoples’ religious and cultural preferences.

Interpreters were available when required for patients whose first language was not English.
All clinics and locations had processes in place to meet the needs of patients with a hearing disability. We observed signs which indicated the hearing loop system was in place for those who required it.

**Access to the right care at the right time**

The trust has not supplied percentages or numbers around the largest ethnicity group within their catchment area but has ranked them from first to fourth highest.

<table>
<thead>
<tr>
<th></th>
<th>Queen Elizabeth Hospital</th>
<th>Birmingham Heartlands, Good Hope and Solihull hospitals</th>
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</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White British</td>
<td>Pakistani</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian (Indian, Pakistani, Bangladesh)</td>
<td>Indian</td>
</tr>
<tr>
<td>Third largest</td>
<td>African Caribbean</td>
<td>Caribbean</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian (Chinese, Philippines)</td>
<td>Bangladeshi</td>
</tr>
</tbody>
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Staff identified where people were in the end stages of their life. Care planning documents were completed for patients relating to end of life care.

Where a patient had a rapidly deteriorating condition and may be entering a terminal phase, an application could be made on their behalf and with consent for the NHS to fund their care (Fast Track Pathway for NHS Continuing Health Care funding). The purpose of this pathway was to expedite care provision in the setting of the patient’s choice. Staff reported delays with NHS Continuing Health Care Funding, this meant care in the community being delayed which led to end of life care patients not being able to have a timely discharge home from hospital.

The service operated a rapid response team, to enable patients to be discharged from hospital whilst awaiting other home care services.

The rapid response team had a rapid response pathway in place. The pathway aimed to facilitate supporting patients in their preferred last place of care or death and preventing admission to hospital. The team provided rapid assessment and treatment of acutely unwell patients in the community as well as providing an initial assessment by a clinician within a two-hour response time.

The rapid response team operated a 24 / 7 service. The team aimed to reduce unnecessary stays in hospital by ensuring people who could be cared for in the community safely would be treated in their own homes by community teams instead of in hospital. The team provided a service to patients in need of urgent care and to palliative and end of life care patients.

The trust operated a hospice at home service, which aimed to enable patients with advanced illness to be cared for at home, and to die at home if that was their preference. Additionally, care was provided to prevent admission to, or facilitate discharge from, inpatient care for crisis management or for longer periods of care.

The trust had a supported integrated discharge team (SID). The team consisted of health professionals from Heartlands and Solihull hospitals work alongside care givers and occupational therapists from the Promoting Independence service at Solihull Council to help patients recover at home safely and avoid being readmitted to hospital.

SID is an example of the work of Solihull – Together for Better Lives. This is a partnership of local health and social care organisations that have put in place a programme, called Integrated Care and Support in Solihull (ICASS), to improve health and social care for older people.
Referrals
The trust had a single point of access to assist staff arrange the right care for urgent and non-urgent referrals, helping to prevent avoidable hospital admissions and effectively manage long-term conditions in the community.

Referrals were undertaken on an adult specialist palliative care referral form. The referral form stipulated the patient must have palliative care needs whether non-cancer or cancer diagnosis for them to be considered by the SPCT.

The SPCT commenced a triage service in 2017 based at the local hospice. The triage service operates 9-5 Monday to Friday and triages all calls concerning palliative and end of life care from both professionals and members of the public

Learning from complaints and concerns

Complaints

From April 2017 to March 2018 there were no complaints about community end of life care.

Staff told us that complaints were handled in line with trust policy, and would advise patients to go to Patient Advice and Liaison Service (PALS), if they were unable to deal with concerns directly. Patients would then be advised to make a formal complaint if their concerns remained.

Staff told us they welcomed feedback from complaints to allow them to develop and improve the service. However, nobody could remember when a complaint was last made about the service.

Staff knew how to raise concerns or make a complaint on behalf of a patient or their relatives. There were posters in clinic areas which told patients and their representatives how to make a complaint and information on the trust website

All patients were given a feedback form on completion of episodes of care. Patients were encouraged to complete the feedback form on completion of episode of care or at regular intervals in their care

All complaints and outcomes were shared at the Community Nursing Quality and Safety meeting, which was attended by team leaders. The team leaders then disseminate the outcomes and learning. Staff told us information relating to complaints and learning outcomes were shared at team meetings

Is the service well-led?

Leadership

Community end of life care was part of division four (HGS). Community services were further split into groups. Community end of life was part of group B. The leadership team at divisional level comprised of a divisional director, divisional director of operations and divisional head nurse. They were supported by matrons and group managers. Day to day management of community end of life care was by the community nursing service leads and the specialist palliative care team.

Local leaders mostly had the skills, knowledge, experience and integrity required to lead community end of life care services, however were not always cited on the risks within the service.
Each community nursing team had a dedicated specialist palliative care nurse from the SPCT based at the hospice to provide information, training, education and support.

The trust had undergone a recent acquisition with a neighbouring trust six months previously, this meant that all priorities for ensuring sustainable, compassionate, inclusive and effective leadership and succession planning were currently being reviewed to amalgamate into a strategy. We were not assured that leaders had identified the challenges to the quality and sustainability of the service, as they were still in the transition period, with no clear vision and strategy.

The trust did not have a non-executive director at board level responsible for end of life care, however the trust told us it was not their intention to recruit one but end of life care was shared out between the existing non-executive directors. They saw end of life care as everyone’s responsibility.

Staff were aware of the leadership structures and told us they received good local leadership and support from their immediate line managers.

Staff described local leaders as visible and approachable. Staff were clear about their roles and the roles of others within end of life care services. Managers spoke confidently about staff they managed, both their professionalism and commitment to the job.

The service was still integrating into the acquiring trust at the time of our inspection, staff were becoming familiar with the organisation as a whole.

Vision and strategy

The trust did not have an end of life care strategy or vision that included prioritised and timebound actions with appropriately allocated leads. The trust advised this was being developed as part of the Sustainability and Transformation plan for Solihull and Birmingham (STP). The STP consists of NHS and social care leaders working together to deliver better health and care in the community for the local population. The STP for Birmingham and Solihull which commenced in 2016 includes community end of life care and is in the process of developing its own local ‘plan’, outlining how it intends to improve the access, quality and financial standards of its local health system. However, the expectation is the service would have their own end of life care strategy which they will have aligned to the STP.

The trust were part of the Aging Well Strategy for Birmingham and Solihull and there was a draft Strategic Commissioning Framework for Adult Community Services, however, this was not specific to end of life care.

The needs of the palliative and end of life care local population were not considered in service planning, however, the trust told us this would be included as part of the end of life and community services strategy development and implementation which is currently ongoing as part of wider Sustainability and Transformation plan for Solihull and Birmingham STP work.

The trust did not have a strategy to address where patients needs and choices were not being met, apart from responding to complaints.

Culture

Staff from both the SPCT and community nurses spoke positively and passionately about the service they provided for end of life and palliative care patients.

Staff were committed to providing and ensuring patients received a good end of life care
experience. Without exception, all staff were dedicated to ensuring patients received end of life care in the way and where they wished.

Staff reported positive working relationships, and we observed that staff were respectful towards each other. All staff we spoke with were clear about their roles and the roles of others within end of life care services.

All staff said they felt confident to raise concerns with their managers. Staff told us they felt well supported by their managers.

Nurses told us that end of life care was always considered a high priority for them. They spoke with pride about the importance of helping individuals achieve a comfortable and pain free death.

The majority of staff we spoke with were knowledgeable about the Duty of Candour, however, nobody could remember when an incident had occurred requiring this. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Staff confirmed there were regular formal information relaying processes including messages from the chief executive. There were monthly team meetings across individual teams. Previous meeting minutes indicated where staff shared good practice and highlighted areas of concern.

Lone working guidance was available to those staff working in the community. Staff we spoke with were vaguely aware of the guidance and some staff were unable to advise us of the actions required. For example, the phrase used if a staff member was in danger or being held at a person’s home against their will.

**Governance**

The governance process for community end of life care was through division four. Governance and managements did not always function effectively. We saw monthly meetings were held to discuss key governance issues, these fed into the quality and safety meetings for risks and issues which was then reported to the quality governance group and then to the board. However, there were currently no strategic end of life care meetings and no service improvement lead for end of life care in the community, therefore we were not sure that sufficient attention was paid to governance aside from the local meetings.

The specialist palliative care team (SPCT) were under the clinical haematology and oncology directorate with governance for end of life care as part of the integrated governance structure.

Each community nursing team were attached to an individual GP practice within a specific geographical area and local social services. Additionally, there was a social worker based at the hospice. This meant there was cross directorate working with partners and third-party providers to promote appropriate interaction and coordinated, person-centred care.

The community nursing teams worked with primary care services within the clinical commissioning group. Clinical commissioning groups are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Policies and procedures were available, each stating the roles and responsibilities of staff within the organisation. Staff were able to access these documents through the intranet.
There were monthly team meetings across individual teams and clear lines of accountability including a structure for cascading information to the senior management team and back down to staff delivering care.

**Management of risk, issues and performance**

We were not assured robust arrangements for identifying, recording and managing risks, issues and mitigating actions were in place, we did not see a risk register for this service, and leaders told us they did not have any risk, as such they did not have a 'worry list'. Risks were seen during our inspection such as staffing shortages, lack of audit programme, poor completion if DNACPR forms were not concerns raised us to by local leaders.

On two occasions, we requested from the trust the risk register for the community nurses and the specialist palliative care team, as staff told us there was one for each team. However, instead the trust sent us the medicine directorate risk register which had an entry for the community nurses stating the trust were unable to continue to provide a safe District Nursing Service due to increased demand and decreased capacity. We could not see any actions in place to mitigate this.

There was limited monitoring of quality measures, for example the lack of monitoring of a patient preferred place of care in the last months/days of life. There was no auditing of the individualised care plans for the last days of life and no evaluation. Furthermore, the trust did not audit pain relief for end of life care or the use of anticipatory medication in community end of life care services.

Mortality meetings took place monthly, where staff discussed patient deaths within community end of life care. The meetings identified the circumstances of the patient, the diagnosis and prognosis, the initial and follow-up care and treatment they had received and the circumstances of the death. We saw evidence of how learning from such situations was shared with the teams.

Duty of Candour was not part of mandatory training, however the trust told us that Duty of Candour was part of the governance section at junior doctor and consultant induction. All incidents were recorded with moderate harm or above were followed up by the governance department to provide advice on Duty of Candour to staff on each specific case.

The trust told us the Lone working policy was out of date but was under review to align with policies as part of the trust acquisition.

Staff we spoke with were vaguely aware of a lone worker guidance and some staff were unable to advise us of the actions required. For example, the phrase used if a staff member was in danger or being held at a person's home against their will.

There was no winter plan for the community end of life care service. Not all the staff were aware of exactly what the process was should the roads become impassable due to inclement weather conditions. However, during the snow storm in February 2018, staff told us that volunteers with specialist vehicles such as four by four cars, assisted as required.

Staff told us, in the event of severe weather, they would contact patients by phone to assess their needs. The service had access to local volunteer drivers with “four by four” vehicles, who were willing to assist with the transportation of staff to essential visits during episodes of severe weather.

**Information management**

Information governance training was mandatory and community nurses told us they were up to date with this training. Following our inspection, we reviewed training information, which demonstrated 100% of the end of life care team had completed information governance training.
against the provider's target of 90%.

The trust used an electronic software which system which had information on all end of life care patients. This meant the identification of known patients and their specific needs were identified daily.

There were sufficient computer terminals in the community teams to enable staff to access the trust’s intranet and external internet information. Trust policies and procedures were available for all staff and accessible through the trust intranet.

Information about end of life and palliative care patients were discussed, at the SPCT daily huddle GP’s made referrals for palliative and end of life care patients using the same electronic referral system as the trust.

**Engagement**

At the local hospice where the SPCT were based, they had recently commenced a Schwartz Round. This is an evidence-based forum for staff from all backgrounds to attend regular meetings to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.

As part of our inspection, we attended the community nursing service organised a ‘You make my day’ event for both staff, patients and care givers. The event was organised to let everyone how valued they were.

The trust used an annual staff survey to obtain feedback. However, there was not a staff survey specifically, for end of life care.

The trust sought feedback from patients using the ‘compliments, comments, concerns and complaints’ form.

New policies and procedures were communicated to staff through staff meetings, emails and the weekly updates. All the staff we spoke with could demonstrate they received regular communication from the board, head of service and team leaders. This meant that staff could keep up to date with current practice and national guidance.

**Learning, continuous improvement and innovation**

The trust did not have a service improvement lead for the community end of life care service and there was no end of life care regional steering group. There was good collaboration and multi-disciplinary working with the local hospice.

The trust underwent an acquisition with another NHS trust six months previously. This has meant significant change for the community teams. Staff told us that plans for improvement and innovation had been put on hold during this time.