Birmingham Heartlands Hospital assessment report

Overall rating: Not rated

Overall location commentary:

Birmingham Heartlands Hospital is an acute general hospital in Bordesley Green, Birmingham. The hospital is part of University Hospitals Birmingham NHS Foundation Trust and is based on a large site in a purpose-built facility. Birmingham Heartlands Hospital provides a range of outpatient, inpatient and emergency care services for its local community.

We completed an unannounced assessment on 19 March 2024 due to concerns raised about patient care and treatment. Based on the information of concern we looked at specific quality statements within safe, effective, responsive and well-led in both medical and surgical services.

As this assessment was based on risk, we only completed quality statements which were connected to the areas of concern and therefore did not complete enough quality statements to re-rate the key questions and service overall. The ratings therefore remained the same as previous for each service. Medical care remained requires improvement for safe, effective and well-led and good for responsive. Surgical services remained requires improvement for safe and responsive and good for effective and well-led.

Overall people’s experience commentary:

During this assessment we spoke with 10 patients and 6 relatives. Feedback we received was largely positive in that patients felt included in their treatment plans and decision making. Patient’s told us they felt safe whilst admitted and the care they received was patients centred. However, within 1 ASG, there were concerns voiced about the length of time taken to answer a call bell.

Medical Care:

Summary:

The medical care services at the trust provide care and treatment for 10 specialities across the 4 main sites: Queen Elizabeth Hospital Birmingham, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital. The trust had over 1,500 inpatient medical beds, 462 of these beds being based at Birmingham Heartlands Hospital.

During our assessment we visited the respiratory ward (Ward 24), cystic fibrosis unit (Ward 26) and acute/hyper acute stroke ward (Ward 32). As part of our assessment, we looked at 6 patient records, spoke with 3 patients, 4 relatives and 8 members of staff including ward managers, a matron, a doctor, nurses and health care assistants.

As this assessment was based on risk, we only assessed quality statements which were connected to the areas of concern and therefore did not complete enough quality statements to re-rate the key questions and service overall. The ratings therefore remained the same as previous for each service. Medical care remained requires improvement for safe, effective and well-led and good for responsive.

We found:

There was evidence of a learning culture, and patients were cared for in a safe environment. However, we did not always find that staffing was safe and effective.

There were processes in place to assess the needs of patients using evidence-based tools. However, we found staff were not always completing them in line with trust guidance.

Staff provided patients with patient-centred care and treatment.

There were governance processes in place and staff knew their roles and responsibilities. However, processes were not always effective.

Overall people's experience commentary:

During our onsite assessment, we spoke with 3 patients and 4 relatives. The feedback from them was mostly positive. They felt staff made them feel safe in the environments where they were admitted and included them in decisions about their care and treatment. They felt staff were aware of their needs and the care provided was patient centred. However, there was concern raised by 1 patient about the length of time it had taken staff to respond to them when they had used their call bell.

Safe

Rating: Requires Improvement.

Key question commentary:

We reviewed the learning culture, safe environments and safe and effective staffing quality statements for the safe key question. As this assessment was based on risk, we did not complete enough quality statements to re-rate the whole key question, safe therefore remained requires improvement.

There was a positive learning culture with staff managing incidents well. Learning from incidents was evident, including the incident which triggered this assessment. Staff knew what incidents required reporting and how to report them. When things went wrong, staff were aware of the principles of being open and honest and where required, implemented the duty of candour. The processes in place supported staff to report and learning from incidents.

Safe Environment: The design of the environment followed national guidance. Staff had access to enough equipment to enable them to complete their roles and equipment was regularly serviced and well-maintained. Our observations of patients in the care environment were positive, patients had access to their call bells, and when faults were reported, these were managed well, and mitigation put in place to ensure patients remained safe.

Safe and effective staffing: There were processes in place to ensure the service had enough staff with the right training, skills and qualifications to keep patients safe from avoidable harm. However, during our onsite assessment and when reviewing additional evidence, we found staffing did not always meet the planned requirements.

Quality statements

Learning culture:

Score: 3

Feedback from staff and leaders

Score: 3

Staff mostly raised concerns and reported incidents and near misses in line with the trust's policy. The trust had a clear incident management policy that explained how to report, categorise, and investigate incidents. Staff told us they knew how to follow this policy and who to contact if they had any questions or concerns. Healthcare assistants we spoke with on Ward 24 felt confident to raise concerns with the ward sister and when they needed to. Staff understood the online reporting system and were comfortable using it. Senior staff gave an example of when a safer swallowing issue was escalated to a speech and language therapist and raised as an incident. There had been no never events reported for the service. However, an incident which triggered this assessment had been reviewed against the never event guidance and was deemed not to have met the classification. Staff told us they were

encouraged to drive improvement for the service. For example, following a specific incident on Ward 26, the service developed a document for enhanced observation. It required staff from care companies to complete hourly checks on patients. Senior staff had done a case study relating to a recent specific incident and intended to present it in a team meeting. The case study had been presented at the clinical dashboard review on preventing harm. The message was cascaded down to all wards at divisional level through band 7s and matrons. Learning from the incident was shared via message of the week.

Processes

Score: 3

There were processes in place for staff to follow when reporting incidents. Incidents were discussed as part of regular huddles and meetings, and where learning was required, there were processes to follow for staff to ensure this was shared and embedded. Where serious incidents had occurred, staff formally undertook the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. We reviewed a selection of incidents and complaints and found these had been investigated in line with the trust's processes and duty of candour letters sent to families for the incident and response letters which covered all relevant elements were completed.

Safe and effective staffing:

Score: 3

Feedback from staff and leaders

Score: 3

Managers told us they accurately calculated and reviewed the number and grade of nurses and healthcare assistants (HCAs) needed for each shift in accordance with national guidance. The service had reducing vacancy rates. Registered nurse vacancy rate was at 19.6% and HCA vacancy rate was at 12.9%. A trust wide HCA recruitment was planned in May 2024. Staff absences were covered, when possible, with existing staff, staff from other wards or bank staff. In the event of sickness, staff made contact via WhatsApp groups, and we saw evidence of shifts being filled from 10am-6pm. The service had increasing rates of bank and agency nurses. Information provided identified the total external agency staff hours used split between registered nurses and registered mental health nurses at 7,129.6 hours. Managers made sure all bank and agency staff had a full induction and understood

the service. The service had a local induction checklist for bank and agency staff. Nurses in charge of wards or departmental team leaders ensured agency workers received an induction using the agency local induction checklist.

Observation

Score: 2

During our onsite assessment, we found the number of staff did not always meet the planned requirement. In addition to this, we also found additional staff were regularly required to provide additional, enhanced observation of patients due to risks identified through assessments. However, staffing did not always ensure this enhanced supervision was completed. Further evidence reviewed off site found the wards we visited did not always have the planned number of staff working. We reviewed the staffing rota from the 9 to 18 March 2024 on Ward 26. We found 8 shifts where a registered nurse or HCA short. We also found Ward 32 was meant to have 4 registered nurses and 3 HCAs working during the day, however there was a shortage of up to 2 staff members in 9 shifts, in the 2 weeks prior to our onsite assessment.

Processes

Score: 3

There were processes in place for bank and agency staff to undergo a local induction. This ensured items, such as identification badges, were reviewed and important information about ward specific needs and policies were discussed. We reviewed a local induction checklist which ensured staff reviewed evidence of fit testing due to the high risk of respiratory infections on the ward. However, the documents provided were more aligned to local induction of bank and agency staff ‘booked’ through the usual staffing process. Where carers were provided for patients through other routes, such as their regular contracts when in their usual residence, the checklists did not explicitly state they were used for these staff members, despite the contact they were or would have with patients. The trust had a standard operating procedure for recording, monitoring and reporting nursing staffing levels which allowed matrons and the clinical site management teams to review planned versus actual staffing levels on a daily basis. They had the authority to move staff to ensure safe staffing levels were met across the organisation taking into account ward comments and patient acuity.

Safe environments:

Score: 3

People’s experience

Score: 3

Patients told us they felt safe in the environment and had access to their call bells. When patients used their bells, they told us staff usually responded quickly to them. However, a patient on Ward 26 provided details of a time they used their call bell and had waited a significantly long time for a staff member to attend to them.

Feedback from staff and leaders

Score: 3

All staff told us they had access to suitable amounts of equipment to enable them to complete their role. Equipment was well maintained and regularly serviced to ensure patients were kept safe. Examples were provided by staff of how issues were managed well and in a timely manner when they raised concerns about items of equipment. Staff told us they completed regular checks on bed spaces when patients were discharged home. This ensured items such as beds and mattresses were checked prior to the next patient being admitted, and if any faults were identified, staff escalated them immediately.

Observation

Score: 3

The design of the environment followed national guidance. Ward 26 was observed to be a ward containing only single en-suite rooms due to the needs of the patients who were admitted there. Equipment was observed to have been serviced, electrically tested and had details of when next checks were due.

Effective

Rating: Requires Improvement

Key question commentary:

We reviewed the assessing needs and evidence-based care and treatment quality statements from the effective key question. As this assessment was based on risk, we did not complete enough quality statements to re-rate the whole key question, effective therefore remained requires improvement.

The service had access to risk assessments which were based on nationally recognised, evidence-based assessments. However, staff did not always complete and update risk assessments for each patient and risk assessments lacked key detail. Managers were aware of the poor completion and were working with the staff to increase compliance. Managers used information from audits to improve care and treatment for patients.

Quality statements

Assessing Needs:

Score: 2

Feedback from staff and leaders

Score: 2

Staff did not always carry out comprehensive risk assessments for people who used services, and this was not in line with national guidance. For example, ward 26 was a specialist cystic fibrosis unit which cared for patients from all over the Midlands including transitional patients. The service only had side rooms and had developed a standard operating procedure which did not require the ward to receive any patients at risk of falls. We were told the service did not have any patients at risk of falls at the time of our assessment. However, we found a patient had had a fall 3 days prior to our onsite assessment. The patient had a bedrail in place and there was no evidence of any person-centred risk assessments being done. Staff said they had discussed the use of bedrails with relatives but there was no evidence to support this. In addition to the regular risk assessments, we also found a patient who had been moved to Ward 32 under the ‘Push Model’ was sitting in the corridor despite a potential diagnosis of stroke. The patient had been sitting in the corridor since earlier in the morning and no risk assessments had been completed to identify the risks and needs of this patient. We raised this with senior staff at the time of our onsite assessment who said they would take action to keep the patient safe.

Processes

Score: 3

There were processes in place for staff to follow to assess and meet the needs of patients. The trust used the electronic system which had all risk assessments embedded within this and staff were required to ensure these were completed on admission and through various stages of a patient's admission. The assessments included, but were not limited to skin integrity assessments, Waterlow assessments, MUST (malnutrition risk assessment tool), bed rails assessment and manual handling assessments. Where concerns were indicated, there were further assessments for staff to complete or escalate for specialist nurse involvement, including where patients required close supervision.

Delivering evidence-based care and treatment:

Score: 2

Processes

Score: 3

The risk assessments which staff used were evidence-based and widely used and recognised across healthcare. Policies, processes and other supporting documentation in relation to risk assessments and the involvement of carers within patient care was based upon national guidance and polices. The carers SOP referenced relevant guidance as well as legislation including the Care Act 2014. The guidelines for the management and use of bed rails and trolley rails were noted to have relevant guidance referenced within these, including the Medicines and Healthcare products Regulatory Agency (MHRA) details around the safe use of bed rails which were also referenced within the never event description.

Responsive

Rating: Good

Key question commentary:

We reviewed the person-centred care quality statement from the responsive key question. As this assessment was based on risk, we did not complete enough quality statements to re-rate the whole key question. Responsive therefore remained good.

The service was inclusive and took account of patients' individual needs and preferences. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. All patients we spoke to felt involved in their care and understood their condition and treatment plans. We saw examples of person-centred care on the wards we visited.

Quality statements:

Person-centred care:

Score: 3

People's experience

Score: 2

During our onsite assessment, we spoke with patients who mostly told us they had been involved in their care and treatment. However, we spoke with a patient who had their bed rails up who indicated they had not discussed this with the staff looking after them. The staff providing the care and treatment to the patient told us the patient had requested these to be put in place.

Feedback from staff and leaders

Score: 3

Staff told us they completed care plans and risk assessments electronically on the prescribing information and communication system (PICS). Staff were required to complete bedrails assessments twice per day and within 6 hours of admission. A clinical dashboard was available with data taken from PICS. We reviewed the care plan of a patient who had sustained a fall and found a risk assessment had been done including a re-assessment after 6 hours. Staff had taken steps to keep the patient safe following a fall including providing 1:1 care as required. Patients on 4 or more medicines were automatically considered to be at risk of falls. Staff received moving and handling training which covered aspects such as management of bedrails.

Observation

Score: 3

We observed patients within Ward 24 who were being cohorted together due to their risk of falls. Staff were trying to ensure their care and treatment remained person-centred, despite requiring the closer supervision. The bay in which they were cohorted in was more spacious than other bays to accommodate additional equipment and was brighter due to larger windows.

Well-led

Rating: Requires Improvement

Key question commentary:

We reviewed the governance, management and sustainability quality statement from the well-led key question. As this assessment was based on risk, we did not complete enough quality statements to re-rate the whole key question, well-led therefore remained requires improvement.

There were governance processes in place for the service, however, these were not always deemed to be effective and consistent. Staff were aware of their roles and responsibilities and who they were accountable for.

Quality statements:

Governance, management and sustainability:

Score: 3

Feedback from staff and leaders:

Score: 3

The medical division had a clear management structure. The division was split into care groups, such as respiratory, elderly care, acute and diabetes. Each care group had a management team which included a consultant, matron and a ward manager. Leaders delivered messages via team meetings, emails, ward safety boards, ward newsletters, ward WhatsApp groups, daily safety huddles at the beginning of each shift and initiatives, such as message of the week to ensure updates and learning was shared to as many staff as possible. Staff spoke positively and passionately about the care and the service they provided. During our assessment, we saw leaders were present on the wards we visited. Staff said if they had a concern, they would not hesitate to raise it with managers. However, we observed an episode of blame towards a staff member during our assessment. Most staff we spoke with were aware of Freedom to Speak Up Guardians in the trust and knew how to escalate their concerns. Each ward had a clinical dashboard which allowed

managers to review ‘live’ data regarding the completion of risk assessments and care plans. These were reviewed at a monthly clinical dashboard review group. Evidence identified only 1 ward from medicine was invited to each meeting to present their results. One piece of evidence celebrated the success in achieving the target for a specific aspect of the dashboard whereas another item of evidence demonstrated a ward presenting their data in relation to challenges in meeting the target. There was no additional evidence to identify what actions were taken to drive improvements across the other wards or other dashboard elements.

Processes:

Score: 2

There were processes in place to review risks within the service; however, these were identified not to be as effective as they could be. Within the evidence shared, there was minimal detail about the discussion of risks despite identifying there were a number of risks which required work on them but were yet to receive associated action plans. However, when reviewing the respiratory specialty risk register, there were no risks covering Ward 26 despite the issues raised in relation to the incident. A response from the trust had identified staffing constraints and lack of ability to provide close supervision of patients due to the ward being all single rooms as a risk and this was why the patient was only allowed on to the ward if their family and regular carers were involved. This was not evidenced on the risk register for the specialty. No risks were evidenced at all. Additional information provided by the trust identified the trust had undergone a change in the way in which each location was managed and this impacted the governance processes. There had been changes to the processes in place to oversee the risks for each location. There were processes in place to feed into the patient experience group and ensure that relevant issues were raised, and actions identified to address the issues. However, the minutes provided did not evidence the update of the issues raised and actions taken. Learning was shared with staff, but the level of detail varied across different wards. Managers used a number of options to communicate with staff including team meetings, changes meetings, huddles and newsletters. Following the incident which occurred on Ward 26, there was evidence of a case review completed for learning purposes which involved all staff.

Surgery:

Summary:

Surgical services at the University Hospitals Birmingham NHS Foundation Trust are provided at the Queen Elizabeth Hospital Birmingham, Good Hope Hospital, Birmingham Heartlands Hospital and Solihull Hospital. Surgical services at Birmingham Heartlands Hospital includes day surgery, pre-assessment clinic, operating theatres, recovery and has over 200 surgical inpatient beds across 7 surgical wards.

During our onsite assessment we visited Ward 7 and Ward 4. As part of our assessment, we looked at 9 patient records, spoke with 7 patients, 2 relatives and 8 members of staff including ward managers, nurses, nurse associates, student nurses and health care assistants. As this assessment was based on risk, we only completed quality statements which were connected to the areas of concern and therefore did not complete enough quality statements to re-rate the key questions and service overall. The ratings therefore remained the same as previous foreach service. Surgery remained requires improvement for safe and responsive and good for effective and well-led.

We found: There was evidence of a learning culture and patients were cared for in a safe environment. However, the service did not always have enough staff. There were processes in place to assess the needs of patients using evidence-based tools. However, we found staff were not always completing them in line with trust guidance. The service was inclusive and staff provided patients with patient-centred care and treatment. There were governance processes in place and staff knew their roles and responsibilities. However, processes were not always effective.

Overall people's experience commentary:

During our onsite assessment, we spoke with 7 patients and 2 relatives. The feedback from them was very positive. Patients were fully included in their treatment plans and decision making and were made to feel like partners in their care. Patients told us they felt safe whilst admitted and received "excellent care" from the staff who were working on their wards. We also observed feedback collected from patients previously admitted who also provided positive feedback on their experiences.

Safe

Rating: Requires Improvement.

Key question commentary:

We reviewed the learning culture, safe environments and safe and effective staffing quality statements for the safe key question. As this assessment was based on risk, we did not complete enough quality statements to re-rate the whole key question, safe therefore remained requires improvement. Learning Culture: The service provided safe care and treatment. Learning from incidents was evidenced with outcomes of incident investigations and actions required to make improvements shared with staff throughout the service. Safe environment: The design of the environment followed national guidance for safety. The wards were set out in single sex bays and side rooms. Staff carried out daily safety checks of specialist equipment to ensure they were in good working order. The service had suitable facilities and equipment to safely meet the needs of patients and their families. Safe and effective staffing: The service did not always have enough nursing and support staff to keep patients safe and to provide the right care and treatment. The service had high vacancy rates which they were actively trying to recruit into. Managers mitigated risks of short staffing by using supernumerary staff and bank staff to support the teams.

Quality statements:

Learning culture:

Score: 3

Feedback from staff and leaders

Score: 3

Staff told us they were encouraged to report incidents and received feedback from incidents they reported, and learning was shared from other incidents. All staff we spoke to told us they felt confident to speak to their managers about incidents and were supported to do so. We were told there was good wellbeing support if needed to ensure staff were mentally well at work. Wards had daily safety huddles where incidents and learning were shared with staff. Manager shared key information including actions for improvements within an encrypted social messaging group, newsletters and at team meetings. We saw a letter sent to all staff by the ward manager following an incident which detailed the findings, and the actions needed to make improvements. Most staff we spoke with could recall recent incidents and the changes needed to drive improvement. Staff shared key information to keep patients safe when handing over their care to others. We observed a handover and found it to be detailed and thorough. Staff had a good understanding of the duty of candour and understood their responsibilities. Staff gave patients and families a full explanation and apology when things went wrong. We looked at 2 serious incidents for the service and both were fully investigated, and the duty of candour was followed. Staff understood the policy on complaints and how to handle them. Managers investigated complaints and identified themes. Were viewed 5 complaints and all were responded to appropriately and showed learning and changes made. Managers shared

feedback from complaints with staff and learning was used to improve the service. We were told about a complaint where the communication at the end of a patient's life was poor. The staff involved were booked onto communication training to ensure they improved their skills and learned from the complaint; this was also discussed in a team meeting.

Processes

Score: 3

There were processes in place for staff to follow when reporting incidents. Incidents were discussed as part of regular huddles and meetings, and where learning was required, there were processes to follow for staff to ensure this was shared and embedded. Where serious incidents had occurred, staff formally undertook the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred. We reviewed 2 incidents where the duty of candour had been applied and found no concerns with how the service had completed this.

Safe and effective staffing:

Score: 3

Feedback from staff and leaders

Score: 2

The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. One staff nurse told us they often did not get their notes completed fully as they were always short staffed; this was reflected in the 9 sets of notes we reviewed. Another member of staff told us that it "feels unsafe some days". All staff we spoke to said they were always short staffed and on ward 4, there were times when they had 12 patients to 1 nurse. Managers also told us they were short staffed daily. Staff told us staffing shortages was on the risk register and mitigations in place. The service had high vacancy rate of 13% across the 6 surgical wards for nurses and 9.5% for healthcare assistants. There were a high number of vacancies within the areas we visited. There were 20 vacancies for staff nurses and 13 for healthcare assistants. Managers were taking appropriate steps to address vacancy gaps. This included an ongoing nursing recruitment programme including overseas nurses. Following a recent recruitment drive, a number of vacancies had been filled and staff were awaiting start dates. Managers used bank staff who were familiar with the service. We were told they did not often use agency staff. The wards mostly used agency staff for

registered mental health nurses only. Between 26 February 2024 and 26 March 2024 a total of 2,348 hours were used for agency and only 19 of these were for registered nurses, the rest were for mental health nurses. Where there were shortfalls in staffing, managers escalated these to the site team and nurses were provided, where possible, from a bank of nurses used to support the wards when required. Staff told us the service had a sickness rate of 4.68% for nursing staff within the last 12 months. Ward 17 had increasing sickness rates; in February 2024 it was its highest at 18.01%. Information reviewed after this assessment confirmed this.

Observation

Score: 3

During the onsite assessment we saw that actual staffing numbers did not always match the planned numbers. Both wards we looked at were reviewing their current establishment. We saw on 19 March 2024 on ward 4, they were 2 nurses short of their established numbers. We were told they should have 6 nurses and 4 healthcare assistants on in the day and mostly had 4 nurses and 3 or 4 healthcare assistants. The ward manager had a few international nurses who were awaiting their qualifications, and they helped to bolster the nursing numbers by working supernumerary alongside the nurses. There was a structured plan for developing these nurses and completing their competencies.

Processes

Score: 3

There was a process in place to ensure wards were adequately and safely staffed at all times. Authority was given to managers in each area to take action when staffing had not reached or exceeded minimum staffing levels. When mitigation was not completed and all options exhausted such as the trust's own bank, managers submitted requests for further support from external agency staff. The wards which were visited recorded low use of agency registered nurses; however, it was noted matrons were not restricting the use of agency for providing registered mental health nurses to provide support to patients. A standard operating procedure was provided to support managers in ensuring staffing within ward areas was safe. There were processes in place for bank and agency staff to undergo a local induction. This ensured items such as identification badges were reviewed and important information about ward specific needs and policies were discussed. We reviewed a local induction checklist which ensured staff reviewed evidence of fit testing due to the high risk of respiratory infections on the ward. However, the documents provided were more aligned to provide local induction to bank and agency staff 'booked' through the usual staffing process. Where carers were provided for patients through regular contracts, the checklists did not explicitly state they were used for these staff members, despite the contact they would have with patients. There were processes in place to support the involvement of carers in the patient's admission. We reviewed the Standards for supporting carers document, version 2 which provided standards

for the integration of carers and seeing them as equal partners in the care and treatment of patients. These processes appeared to mainly focus on carers that were not employed in the role of a carer (for example family and friends) and not necessarily in the similar situation as the incident which triggered this assessment.

Safe environments:

Score: 3

People's experience

Score: 3

Patients could reach call bells, and they told us staff responded quickly when called. We spoke with 7 patients, and they all told us they felt safe. One patient told us "The ward is excellent; the level of care is very high. I feel safe as the staff are professional and check in on me." Patients told us their risks were assessed. For example, they were asked if they wanted their bed rails up or down. One patient told us "I had the bedrails up when I had my surgery, otherwise I don't keep them up".

Feedback from staff and leaders

Score: 3

Staff told us the equipment was safe and they had access to suitable equipment to carry out their role. They told us they carried out daily safety checks and we saw these were completed consistently. The service had suitable facilities and equipment to safely meet the needs of patients and their families. Staff disposed of clinical waste safely. Staff told us that when equipment was found to be broken, they removed it from the area, labelled it as faulty and logged this with the estates team. We were told beds and mattresses were checked each time a patient was discharged from the bed to ensure they were in good working order. All staff received training on medical devices when they started within the trust. There were core trainers on the wards for specific equipment who trained staff in their ward area when required. Managers were aware where the environment was not suitable and had plans in place to make improvements. The risk register highlighted that ward 18 had a poor environment with a plan in place for potential refurbishment.

Observation

Score: 3

The design of the environment followed national guidance. We saw the facilities and equipment were well maintained and used for intended purpose, stored securely, and used properly. All equipment we checked had an up-to-date electrical safety check.

Effective

Rating: Good.

Key question commentary:

We reviewed the assessing needs and evidence-based care and treatment quality statements from the effective key question. As this assessment was based on risk, we did not complete enough quality statements to re-rate the whole key question, effective therefore remained good. The service had access to risk assessments which were based on nationally recognised, evidence-based assessments. However, staff did not always complete and update risk assessments for each patient and risk assessments lacked key detail. Managers were aware of the poor completion and were working with the staff to increase compliance. Managers used information from audits to improve care and treatment for patients.

Quality statements:

Assessing Needs:

Score: 3

Feedback from staff and leaders

Score: 2

Nurses handed over patients to nurses using the electronic system. This meant they could alert staff they were handing over to about any risks the patients had and any outstanding care needs. Managers could monitor the completion of risk assessments using the clinical dashboard. For example, on 19 March 2024, on Ward 4, 56% of care plans were fully complete. Managers used the information from the dashboard within huddles to improve compliance where required. Staff told us managers fed back this information and they were aware that care plans and risk assessments needed improving. Staff did not always complete and update risk assessments for each patient and did not remove or minimise every foreseeable risk. We reviewed 9 sets of records, and all had a completed falls risk assessment and Waterlow assessment; however, the Waterlow assessments lacked detail and action. For example, a patient had a Waterlow of 23, which was considered very high, and there was no documentation that a mattress was in place, skin integrity checks were completed on 5 out of 14 occasions and there was no documentation of whether the patient required turning. This meant we were not sure the risks of patients developing a pressure sore were reduced. We saw that skin integrity checks were not fully completed in all notes that we reviewed. Within the 9 notes that we reviewed, patients' skin integrity was fully checked on 37 out of 102 episodes of care rounds. We did not see clear documentation of patients being turned when they were at risk of developing pressure sores. This had been recognised by the manager and

posters prompting staff to turn their patients were on the walls. One staff member told us they had raised the poor completion of skin checks with the manager as they had seen it decline. Managers said they were aware that completion of risk assessments and daily care plans needed improvement and we saw evidence that managers were working to improve compliance.

Processes

Score: 3

There were processes in place for staff to follow to assess and meet the needs of patients. The trust used an electronic system which had all risk assessments embedded within this and staff were required to ensure these were completed on admission and through various stages of a patients admission. The assessments included, but were not limited to skin integrity assessments, Waterlow assessments, MUST (malnutrition risk assessment tool), bed rails assessment and manual handling assessments. Where concerns were indicated, there were further assessments for staff to complete or escalate for specialist nurse involvement, this included where patients required close supervision. Bed rails assessments were not always completed daily as per protocol. We looked at 90 daily care plans across 9 sets of notes and found that of these 90, 31 bed rails assessments were completed. We found that bed rails were discussed regularly between staff and patients. We listened to a handover and the nurse handed over that a patient wanted their bed rails up even though there was no indication for it.

Outcomes

Score: 2

Managers regularly completed audits on the completion of risk assessments. In addition to audits, the service also used a clinical dashboard which gave real time data on the performance against a set of indicators. Risk assessments (Waterlow, falls, MUST) were included as key indicators on the dashboard. Information reviewed on the clinical dashboard review group minutes identified surgical wards had been identified as decreasing in their performance against some key indicators. This was believed on 1 ward to be due to removing the Surgical Assessment Unit SAU) from the ward area. There was no information within these meetings in relation to any bed rails risk assessments and the performance in relation to them. There was also a lack of outcomes in relation to the number of falls, pressure damage or patients who were harmed by the poor MUST assessment within the evidence provided.

Delivering evidence-based care and treatment:

Score: 3

Processes

Score: 3

The risk assessments which staff used were evidence-based and widely used and recognised across healthcare. Policies, processes and other supporting documentation in relation to risk assessments and the involvement of carers within patient care was based upon national guidance and polices. The carers Standard operating Procedure (SOP) referenced relevant guidance as well as legislation including the Care Act 2014. The guidelines for the management and use of bed rails and trolley rails were noted to have relevant guidance referenced within this, including the Medicines and Healthcare products Regulatory Agency (MHRA) details around the safe use of bed rails which was also referenced within the never event description.

Responsive

Rating: Requires Improvement.

Key question commentary:

We reviewed the person-centred care quality statement from the responsive key question. As this assessment was based on risk, we did not complete enough quality statements to re-rate the whole key question, responsive therefore remained requires improvement.

The service was inclusive and took account of patient's individual needs and preferences. Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. All patients we spoke to felt involved in their care and understood their condition and treatment plans. We saw examples of person-centred care on the wards we visited.

Quality statements:

Person-centred care:

Score: 3

People's experience

Score: 3

All patients we spoke to understand their condition and treatment plans. Patients and families were supported and involved in planning for discharge. We were told staff arranged for family members to attend doctors' ward rounds to involve them in decisions were needed. Patients told us that staff communicated well and kept them informed about any changes to their condition and treatment. We spoke to 7 patients and 2 relatives. They all told us that they were involved in the decision-making process and had options explained to them. One patient told us, "I was fully involved in any decision making and they made sure I understood all complications around my procedure. They had explained all my options I had, the risks to each stage and how they would approach it. I feel so supported." Visiting times for all wards were from 11am until 8pm. Relatives felt involved in the patient's care, were able to help at mealtimes if required and felt they could easily speak to staff and doctors if required. The service completed friends and family tests where they collected feedback from patients and their relatives. These were analysed by the managers and acted upon where needed to make improvements. We saw 3 examples of feedback from 18 March 2024, and they were all positive and included comments, such as "good service by the nurses" and "satisfied with all the staff. They are doing very well all the time and helpful".

Feedback from staff and leaders

Score: 3

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Staff told us about how they had thought about their patients' best interests and acted to ensure the care they received was right for them. For example, we were told about a patient who lacked capacity due to living with learning difficulties. The service involved an independent mental capacity advocate to hold a best interest meeting. They met alongside clinicians and the patient's family and discussed the patients care and how to manage the care moving forward. Staff told us this felt very patient centred, it felt right and that 'the patient really matters'. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We listened to a handover where a nurse talked about a patient who had autism and was vulnerable. They had refused a hospital passport and handed over to the other nurse the specific likes and needs of the patient to ensure the care was person-centred.

Observation

Score: 3

We observed staff discussing patient care in a person-centred way. We listened to a handover and found it to be detailed, and risk based and included discussions about how patients felt and what staff could do to improve their experience. For example, a patient who was living with autism did not like to be woken up or have their bloods taken in the morning. The staff had put them in a side room to reduce their distractions and had arranged for their blood to be taken later in the day. We saw there were communication boxes on the wards which had devices to assist with patients who were hard of hearing.

Well-led

Rating: Good.

Key question commentary:

We reviewed the governance, management and sustainability quality statement from the well-led key question. As this assessment was based on risk, we did not complete enough quality statements to re-rate the whole key question, well-led therefore remained good.

There were governance processes in place for the service, however these were not always deemed to be effective and consistent. Staff were aware of their roles and responsibilities and who they were accountable for. The main risk in surgery was

staffing levels and whilst there was a number of vacancies across the service, a large proportion of these vacancies had been recruited into.

Quality statements:

Governance, management and sustainability:

Score: 2

Feedback from staff and leaders

Score: 3

Staff told us there were governance, management and accountability arrangements in place, and that they understood their role and responsibilities, what they were accountable for, and to whom. However, further discussions and reviewing of information to triangulate our findings found the arrangements in place were not always effective and consistent. We were told the clinical delivery groups had quality and safety committee meetings where they reviewed incidents, complaints, audits. Matron fed back key messages from the quality and safety committee meetings to the ward managers who then implemented changes as needed. Managers told us about improvements they had made following feedback from governance meetings. For example, in September 2023, ward 7 had poor compliance with the completion of risk assessment paperwork within 6 hours of a patient being admitted to the ward. The manager had talked about this within the safety huddle, spoken to individuals and completed an analysis of the data. They found that the poor compliance was often on the night shifts and therefore wrote a letter to the night staff to raise awareness and improve compliance. They had seen the overall compliance increase following this from 20% in September 2023 to above 70% in February 2024. Staff told us they received feedback from audits that were undertaken. We observed a changes meeting on Ward 7 where the nurses had an update following the doctor's rounds. The nurse discussed the patients but also discussed a recent controlled drugs audit which scored 92% and the improvements needed to increase compliance. We also saw audits were discussed in team meetings and huddles and documented on notice boards for staff to see. During the onsite assessment, staff told us there had been work completed to drive improvements and share learning in relation to compliance with documentation. However onsite evidence collected identified there was still poor compliance.

Processes

Score: 2

The surgical service had a clear management structure. It was managed by an associate director of nursing and was split into 3 clinical delivery groups, each with their own matron. Each ward was managed by a ward manager. The service had a clear governance structure with various committees. There were monthly

governance meetings within each clinical delivery group which fed into a quarterly clinical governance meeting. We reviewed 3 sets of clinical delivery group meetings that showed there were processes in place to review risks within the service. However, these processes were not as effective as they could be. The evidence we reviewed was brief and there was minimal detail about the discussion of risks despite identifying there were a number of risks which required work on them but were yet to receive associated action plans. We also found there were minimal details in relation to audit outcomes and incident information. Additional information provided by the trust identified the trust had undergone a change in the way in which each location was managed and this impacted the governance processes. There had been changes to the processes in place to oversee the risks for each location. Learning was shared with staff, but the level of detail varied across different wards. Managers used a number of avenues to communicate with staff including team meetings, changes meetings, huddles and newsletters. Both areas we visited also told us they used an encrypted social media application for communication. We reviewed ward meeting minutes for ward 4 which kept staff informed. However, other minutes provided after the assessment were not as comprehensive as these and therefore raised concerns over the consistency across the service. Clinical dashboard data was discussed monthly, however only 2 areas achieving targets were discussed. This did not identify how the areas which were not meeting their targets were managed or what action was taken to drive improvements.