

Heart of England NHS Foundation Trust

Quality Report

Heartlands Hospital
Bordesley Green East
Birmingham, B9 5SS
Tel: 0121 424 2000
Website: www.heartofengland.nhs.uk

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

Ratings

Overall rating for this trust	Requires improvement	
Are services at this trust safe?	Requires improvement	
Are services at this trust responsive?	Requires improvement	
Are services at this trust well-led?	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

Heart of England Foundation Trust is a large NHS provider of acute hospital and community services in Birmingham and Solihull. The hospitals are in the East and North of Birmingham and one smaller site in Solihull West Midlands. There is also the Birmingham Chest Clinic which is in the centre of Birmingham. The trust has some community services in Solihull. We did not inspect the community services or the Chest Clinic. The three acute sites are Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital. Along with the community service the trust serves approximately 1.2m people. The Birmingham Heartlands site is where the trust headquarters are located.

We carried out this unannounced responsive inspection because the trust was in breach with regulators Monitor, and we had received intelligence which warranted our response and so we arranged the inspection. The inspection took place between 08 and 11 December 2014. We had inspected the service in November 2013 and the trust was still working through compliance action plans. While progress has been made since our last visit, this is limited and not yet sufficient.

We specifically focussed on A&E, Medicine, Surgery, Maternity and Outpatients Departments on all three sites.

This inspection was an unannounced responsive inspection. The purpose of the report is to share with the trust and the public the evidence we gathered during that inspection. It is also important to note that at the time the trust leadership was in transition with many changes within the trust executive team, some of whom were in interim posts. This had been precipitated by the previous Chief Executive resigning in November 2014.

While we found some evidence of progress since the last inspection we did find in others no improvements or deterioration.

Our key findings were as follows:

- Widespread learning from incidents needed to be improved.
- Appraisals for staff were not widely undertaken achieving 38% compliance at the time of our inspection; which would equate to 57% by year end.
- Staffing sickness and attrition rates were impacting negatively on existing staff.
- The poor patient flow mainly in BHH and GHH was having negative impacts across all the core areas we inspected. For instance the number of patients having to wait in recovery more than 30 minutes was high.
- Referral to treatment times were not always met for people. It was present on the Board assurance framework and posed a reputational risk to the trust as well as a risk to patients waiting for treatment.
- Discharge arrangements required improvement; we saw that only 35% of patients were discharged on or before their planned date of discharge.
- The care of the deteriorating patient was generally managed well.
- Arrangements for patients with reduced cognitive function were not always effective. This meant that some patients did not receive the level of care and support they required.
- The leadership was in a transition phase with some in interim posts including Chief Executive and Medical Director.
- The culture within the trust was one of uncertainty due to the number of changes which had occurred.
- Staff could not communicate the trust vision and strategy.
- Governance arrangements needed to be strengthened to ensure more effective delivery.
- IT systems needed to be improved to ensure reporting was accurate. The ability of the trust to report against activity was not always available for use at trust level or to their commissioners.

We saw several areas of outstanding practice including:

- On the Acute Medical Unit (AMU) at Birmingham Heartlands Hospital (BHH) local complaints resolution was very responsive to patient's needs. The complainant was invited to a meeting and given a recording of the discussion. This appeared to resolve complaints quickly.
- AMU, Ambulatory Care, wards 10, 11 and 24 on the BHH site provided excellent local leadership, services were well organised, responsive to patients individual needs and efficient which resulted in excellent patient outcomes.

Summary of findings

- The Practice Placement team provided excellent links between the trust and the University in supporting more than 600 student nurses across all three hospital sites.
- Sexual health team demonstrated how they used information such as audit and patient feedback to improve services to patients.
- We saw caring was good across the trust. We did not review caring in this report; but had no concerns about the caring of staff in the trust.

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

- BHH Emergency department was overcrowded with poor flow, leading to a high stress, high risk environment for both patients and staff.
- Arrangements for patients who required mittens were not undertaken to maintain patient's safeguards. The hospital staff was applying mittens to some patients (to prevent removal of nasogastric tubes etc) without the necessary Deprivation of Liberty Safeguard assessments being in place.

Importantly, the trust must:

- The trust must take effective action to achieve consistent staff compliance of infection control procedures within the emergency department.
- The trust must address the ambivalence held by staff about reporting incidents as they may be underreporting and trust could miss important trends.
- The trust must ensure that staff are clear about clinical responsibility for patient's awaiting handover by Ambulance services in the emergency department at Heartlands.
- The trust must take effective action to address the crowding in the majors area of the ED department and ensure that staff on duty can see and treat patients in a timely way.

- The trust must ensure all patients requiring items of restraint such as hand control padded mittens are supported with a mental capacity assessment, a DoLS and are regularly reviewed by the MDT which is recorded in the patient's notes and mittens are replaced when soiled. A consistent practice must be adopted across the trust.
- The trust must replace or repair essential equipment in a timely manner.
- The trust must provide sufficient staff to operate the second obstetrics theatre at night, and prevent delays occurring.
- The hospital must improve the information available to outpatients departments to ensure that these are monitored and action taken to improve services through audit, trending and learning.
- The trust must review the operation of rapid assessment of patients to improve its consistency and effectiveness.
- Improve the environment of the transfer corridor used to transport patients and dispose of refuse appropriately at the Good Hope site.
- The trust must improve arrangements regarding patients following surgery having to wait in recovery over 30 minutes.
- The trust must ensure all fire doors and exits are free from clutter.

There were also areas of practice where the trust should take action, and these are identified in the report.

As a result of this, the trust will be subject to regulatory action as requirement notices and a comprehensive inspection will be carried out to confirm this.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Heart of England NHS Foundation Trust

Heart of England Foundation Trust employs 10,318 staff, of which 3,400 are nurses, 1,100 doctors and consultants, 1,700 allied healthcare professional and 1,200 healthcare assistants.

The trust has approximately 1,523 beds.

The trust sees (2013/14) around

- 238,000 patients in its A&E Departments;
- 80,000 day case and elective patients;
 - 1,200,000 patients in Outpatients;
 - 10,000 births.

The population is culturally diverse with 46.9% non-white residents.

This trust is a Foundation Trust. It is part of the NHS and provides over half of all NHS hospital, mental health and ambulance services. NHS foundation trusts were created to devolve decision making from central government to local organisations and communities.

Heartlands and Solihull Hospitals merged in 1995 and were joined by Good Hope Hospital in 2007. Finally joined by Solihull Community services in 2011. The organisation became a Foundation Trust in 2005.

The trust annual income was over £600m (2013/14).

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper

Inspection Manager: Donna Sammons

The team included CQC inspectors and a variety of specialists: Within the team were specialist advisors who had experience in accident and emergency, surgery and theatres including maxillofacial surgery, Medicine including respiratory medicine, cardiology and maternity and gynaecology. Within the team the specialists held positions which included;

- Professor of Medicine
- Consultants

- Junior doctor
- Registered Nurse and a newly qualified Nurse
- Registered Midwives
- Paramedic
- Associate Director of Governance
- Unit and Hospital Managers

Within our team were two experts by experience, who had experience either individually or with a family member having used the services of a NHS provider.

You should also be aware that experts who take part in the inspections are granted the same authority to enter registered persons' premises as the CQC inspectors.

How we carried out this inspection

We carried this inspection out as an unannounced responsive inspection; and therefore the trust had no advanced notice of our inspection visit. We visited the three acute sites and talked to patients and staff including focus groups. Following the inspection we reviewed documents supplied to us by the trust.

We considered the trust under three of our five domains, and asked

Are services safe?

Are services responsive to patient's needs?

Are services well led?

We looked at four of our eight core services in detail and also looked at trust wide leadership. We visited

- Emergency Department (A&E)

Summary of findings

- Medicine
- Maternity
- Outpatients and diagnostic imaging.

We looked at surgical services but an internal technical difficulty has prevented us being able to write a report at the detail we would wish, and summary information only has been provided.

What people who use the trust's services say

The friends and family results for October 2014 had a 30% response rate. The net promoter result was 60.

Facts and data about this trust

We have no additional facts about the service as this was an unannounced inspection so we were not able to develop a data pack for the trust and team.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Summary</p> <p>Learning from incidents needed to be improved across the organisation. There were good communication tools utilised to share learning but staff still felt a gap in their knowledge. Appraisals needed to be undertaken for more staff, and a rate of 38% was recognised by the trust as insufficient.</p> <p>Staffing was an issue with staff sickness and attrition having a negative impact on staff on the units. The spending on bank, agency and locums was increasing from the previous year. There were some concerns about the quality of work undertaken by agency and locum staff.</p> <p>Some emergency arrangements needed improvement notably within maternity regarding the pre-eclampsia box, either not checked or misplaced. Ward 2 at Heartlands hospital did not check the resuscitation trolley in line with trust policy.</p> <p>Some equipment was not being replaced in a timely fashion when staff and patients required it.</p> <p>Safeguarding patients who had been risk assessed as requiring mittens, we found staff were not following trust policy with regard to restraint or deprivation of liberty's safeguards.</p> <p>Recognition of the deteriorating patient appeared to be being managed well, with clinical reviews sought when required.</p> <p>Incidents</p> <ul style="list-style-type: none">• There were five never events all related to surgery and one prevented event 2013/14. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.• Training for incident reporting was 100% across the trust. We found that staff understood how to raise incidents, but we found that feedback was an issue, and some staff did not report all incidents. Such as outpatients, not reporting when clinics were delayed. Across all the core services staff complained regarding the lack of feedback from incident reporting.• Surgery reported that they did receive feedback from incidents and were given opportunities to learn from them.• The trust was using a publications such as "Risky Business", Matty Matters and "SUI at a glance" to make staff aware of incidents and the learning from them.	<p>Requires improvement </p>

Summary of findings

- Another publication “ED Pearls” was used effectively to increase learning within the medical staff, and was further used to help form training content.
- ‘Walkabouts’ were undertaken to see if learning from incidents was being implemented and changing practice. The quality and risk committee felt that the learning was mixed and required further work by the Safety and Learning Engagement manager.
- The Trust monitored its mortality rate on a monthly basis using the Hospital Standardised Mortality Rate (HSMR) available from Dr Foster and on a quarterly basis using the Summary Hospital Level Mortality Indicator. This was an improved position from our last inspection.
- Mortality reviews occurred, but these were undertaken by medical staff. Nurses did not attend citing lack of time.
- Incidents about staffing levels were not being routinely recorded on the electronic incident system. Staff thought the capacity to do so had been removed or moved as too many incidents of staff shortage was being reported. With further inspection we found it was on the system but be a different route that most staff were unaware of.

Cleanliness, infection control and hygiene

- Infection control practices were not always followed; we saw incidents of staff not being bare below the elbow, wearing ties in clinical areas and wearing the same gloves to deliver care to two patients. We raised these occurrences at the time of our inspection.
- We saw that despite staff making others aware of noncompliance with trust policy this did not always result in a change of behaviours.
- We saw in medicine that infection control practices were well managed, audited and results shared with patients and visitors.
- The trust undertook audits of infection control compliance as a means of being vigilant to keep this practice in the forefront of staff minds. Where audit identified failings action plans were put in place.
- Within BHH (Birmingham Heartlands Hospital) and GHH (Good Hope Hospital) ED (Emergency Department) was extremely busy, and the cleaning was the responsibility of one housekeeper and nursing and HCA staff on each unit. We found the BHH site to be dirty with some infection control issues.

Environment and equipment

- GHH emergency department underwent a refurbishment in 2013; we saw that the space was well designed for the use of both the public and staff.

Summary of findings

- Within maternity on the BHH and GHH sites staff were concerned regarding lack of equipment, such as blood pressure cuffs and a low risk deliveries room being used for storage. In addition to this a fridge for the storage of blood had been out of order for about two months prior to our inspection. A blood fridge is always provided near the labour wards, blood loss is a known risk in childbirth; and blood supplies appropriately stored close to hand are important. Mitigation was in place but this was not efficient use of resource. Following the inspections we were made aware that the fridge had been replaced.
- Medical wards at SH (Solihull Hospital) were cramped and lacked space for patient privacy and storage of equipment.
- We were made aware of some equipment which was faulty and out of use which had been reported but not addressed in a timely manner.

Medicines

- The pharmacy department had systems and processes in place which safely stored, recorded and maintained medications. Electronic prescribing was in place which allowed the monitoring of prescribing and administration. This ensured that issues in respect of medication was reported and action taken to address deficits.
- Within Maternity on the GHH and SH sites the emergency arrangements needed to be addressed. Specifically the emergency pre-eclampsia boxes in antenatal clinics. At SH the box which required weekly checks had only been checked twice in 2014. At GHH staff were not able to locate it in a timely fashion. Both instances could put women at risk in the event of requiring the boxes.

Records

- Across all the acute sites we found that information governance was not adhered to. Notes trolleys were routinely left unattended and open near nurses stations. The notes were at risk of being tampered or removed.
- Nursing documentation was incomplete on the flex ward at SH. This included reviews of skin integrity, nutrition and manual handling. We were made aware that the flex wards had a large percentage of agency staff. These reviews not being undertaken raised the risk for patients and we had already seen an increase in patient harm metrics.

Safeguarding

- The occurrence of avoidable pressure ulcers are an indicator of patient harm. Documents supplied to us by the trust recorded

Summary of findings

the instances from November 2013 to October 2014. We noted that from February to June 2014 the number was fairly stable ranging from 15-21 occurrences. August 2014 is notable having the highest number of occurrences at 42 for the 12 months represented. However the numbers had fallen for the following two months to 23. We were not able to ascertain the severity of the pressure ulcers as that information was not present in the report; although this information is available ward by ward.

- The use of mittens was not well managed across both BHH and GHH (Good Hope Hospital) sites. Patients who had been identified at risk of removing their nasogastric tubes were wearing them. This is considered a form of restraint; however none of the associated safeguards had been undertaken for their use. Patients had not received mental capacity assessments for best interest or subsequent deprivation of liberties safeguards applications. We did inform staff and the Chief Executive at the time of our inspection so this could be addressed immediately.

Assessing and responding to patient risk

- Within BHH ED there was some uncertainty about who was responsible for patients when they were in the department. When patients had been brought in by the ambulance crew who offered a HALO (Hospital Ambulance Liaison Officers) service. When the ED was busy and they wanted to hand over patients they experienced delays at times. It was at these times it was not clear who had clinical responsibility for the patient.
- The system in place to identify higher risk patients did not always work. Not all patients who attended ED with chest pain were identified allowing them to be seen. We also noted that the protocols for rechecking of deteriorating patients were not always followed; we saw this at both BHH and GHH.
- At GHH within medicine nurses did not routinely attend ward rounds, this posed a risk to patients due to communication disconnects.
- There was no specialist diabetic nurse available to support patients at SH. We saw that this had had a detrimental effect on patients who required support with rapidly changing doses of their medication.
- Within the BHH Ward 2 for medicine was a ward of particular concern, with regard to maintaining patient safety. We saw that emergency practices regarding the resuscitation trolley and risk assessments to ensure harm free care were not always followed.

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Mandatory training

- Mandatory training rates for the trust were 80% dated Sept 2014; the target was set for 85% by March 2015. The trust are on target to meet this training by year end.
- All clinical staff needed to be trained and able to deliver basic life support. Documents supplied demonstrated that at the October HR committee meeting the current position was 72% of staff had undertaken this training. The trust had met its Q1 target and was on target to meet the Q2 target of 74%. The overall target at consolidation was 85%.
- Some nursing staff ran the risk of not meeting mandatory training targets, as they and their managers felt training was secondary to staffing the wards. This view was expressed on the GHH site.
- The trust needed to improve undertaking appraisals for staff reported November 2014 the rate was 38%. This equates to a year end position of 57%. We did note in documents supplied by the trust that many appraisals had now been booked. The appraisals were linked to pay increases some staff told us. Therefore the lack of receiving them was detrimental to staff not only for development but for financial reasons too.

Staffing

- Documents supplied by the trust demonstrated that nursing staffing was an issue. 12% of shifts had experienced a shortfall October 2014. Staff fed back to us during our inspection that staffing was an issue.
- The trust had analysed staff feedback through a number of avenues including a leaver's report, which stated that staff felt high levels of stress, and issues around flexible working. During the focus groups we held staff expressed their dissatisfaction with working across sites and in wards or departments they were unfamiliar with.
- Bank and agency use was high, 35% higher than the previous year.
- An area of risk recognised by the trust was that agency staff did not always have the skills and experience to support trust staff. For instance the trust uses an electronic medication administration tool, agency staff were not trained in its use, and therefore their support on the ward was limited.
- To control the number of agency nursing staff required, the trust introduced an initiative which meant that staff registered with the internal bank would receive enhanced payments.
- Qualified nursing staff numbers against what the trust budgeted was reported at 103%, healthcare assistants are at 112% with a trust target of 114-120%.

Summary of findings

- The sickness rate at the trust for October 2014 was 6.1% which had increased from the previous month from 5.8% and had been rising since April 2014. The trust did have an initiative in place to impact on this one of which involved closer interaction with healthcare assistants (sickness rate October 2014 8.1%), but the trust had noted that at the time this had not had the desired results.
- On the BHH and GHH site for maternity staffing appeared to be an issue in Midwifery, some areas being significantly understaffed. Notably in the second obstetrics theatre at night if a woman required the theatres there was not a second scrub nurse available. Contingency plans utilised could have put other women at risk.
- Medical locum use was also an issue the trust had identified, having undertaken a review of increasing expenditure from August 2013- July 2014. The main reason was vacancy cover, and the directorate with the highest use was A+E. The trust had produced an action plan to address the issue.
- The Infant feeding co-ordinator role had recently been changed so the service was offered only on the BHH and GHH sites, midwife staff at SH told us it was hard due to workload to support mothers when the feeding co-ordinator was on the other site.
- Medical appraisals run September to September. We saw the results for September 2014 which was 80% of doctors had completed appraisals.
- Revalidation is where a 'responsible officer' (usually the medical director, but in this case an Associate Medical Director) makes a recommendation to the General Medical Council, every five years, that the **doctor** is up to date and fit to practise, and should be **revalidated**. The number of deferrals for revalidation was worse (more than doubled) in the current year. In the 12 months of 2013/14 the rate of deferral was 8.5% for 2014/15 (six months) the rate was 18.8%. The trust had recognised this as a concern.

Major incident awareness and training

- Most trust staff were able to describe their role if a major incident occurred. The only exception was outpatient staff on all acute sites; they reported being unaware of a major incident plan and had received no training as to what to do in the event of a major incident occurring.

Summary of findings

Are services at this trust responsive?

Summary

The trust had major issues with flow of patients and capacity to manage them. We saw that in ED, through to the wards and theatres and outpatients the problems were manifesting themselves. The trust had strategies in place and initiatives they were working on, but some of these were not effective, due to staff not utilising them fully. Some were not effective as they were over complicated. Some were not effective because no audit reports were available regarding the effectiveness of the interventions.

People with reduced cognitive function received mixed levels of care which depended on which site and department they presented. However, there appeared to be much space for improvement with this vulnerable group. The arrangements within the Hyper acute stroke unit being at BHH was meeting the needs of that patient group.

AMU at BHH was doing good work with local resolution of complaints for patients.

Service planning and delivery to meet the needs of local patients

- During our inspection we were made aware that the hyper acute stroke unit had opened (HASU). Documents supplied by the trust had identified that they had a target of 50% of stroke patients were to be admitted to a stroke unit within 4hours. The Heartlands site was consistently better performing at this target than the Good Hope and Solihull site. Therefore using the audit data available they have concentrated resources for the HASU to the Heartlands site to improve access to specialist input for patients.
- Language line and access to translators was readily available to staff and patients.
- Lack of service planning or use of audit data for all three OPDs to deliver clinics out of core service hours was evident. Although after parking this was the highest area of concern for people attending.
- To reduce the number of do not attends the booking service initiated a telephone contact system four years ago. The system has not been audited to ascertain if it has been effective in its objective.

Meeting people's individual needs

- There was not a systematic approach with regard to people living with reduced cognitive function.

Requires improvement



Summary of findings

- Dementia assessments is part of a CQUIN, requiring the trust to identify, assess and refer patients. The target has been set at 90% at the time of the inspection the trust had achieved 87% for October 2014.
- We noted in documents supplied by the trust that Dementia care was a priority for quality improvement. To achieve and measure impact the trust had produced standards which identified the actions staff needed to undertake. For instance standard one was “Every unplanned admission for a patient over 75 to result in querying dementia as a known diagnosis”. The target was 90% but the trust achieved 69% March 2014.
- Despite this we found in ED both at BHH and GHH appeared to lack an identification and support system for patients with dementia, learning disabilities or any other mental health diagnosis. People’s needs were not well met in this area.
- SH had closed its dementia ward, but had an in-reach team, which was to support staff and patients on any of the ward where patients are with dementia.
- Within GHH emergency department we did see the area where patients who waited for transport was near an exit and if they were of reduced cognitive function there was a risk that they could leave the department without staff being aware.
- Within the midwifery service there was no provision for women with learning disabilities. When they did present, they were cared for by the teenage pregnancy midwife.
- Within outpatients department at BHH, patients who were vulnerable or with additional needs were accommodated in outpatients.
- Referral to treatment times and cancer waits were not being met. Documents supplied by the trust demonstrated that 2 week cancer waits did not meet target achieving 77.6% from April - September 2014. October was 90% the target was 93%.

Access and flow

- 1,182 patients had missed the 18 week referral to treatment target (July 2014). Although the trust had a plan in place to reduce this number by December 2014 to 500 or below. At the time of the inspection a performance report dated November 2014 stated that 1469 patients had breached 18 week RTT (admitted backlog).
- Within outpatients the bookings process was overly complicated and allowed the trust to effectively run two waiting lists. Dependent on the manner in which GP’s opted to make the referral to the hospital, would determine how long each

Summary of findings

patient waited to receive an appointment. In addition to this the bookings department have a process where they can offer patients an appointment window of up to 18 weeks which effectively meant the trust missed its targets.

- Within ED the 95% of patients seen within the four hour target was breached twice (once in April and again August 2014). In September 2014 it was 89.5%. This was a deteriorating picture for the trust along with the ambulance handover times.
- GHH ED staff expressed little confidence in the escalation policy when the department was busy; they felt the process did not result in any real change. Staff were able to explain the process when the service was at level 4 but when the department was at level 3 were less confident of actual support.
- Capacity was also an issue on the BHH site within ED, with patients waiting for cubicles, which in turn meant that medical staff could not attend them. There were numerous cases of patients who had been identified for admission waiting extended lengths of time to be moved to a ward.
- The trust had invested in working with local independent health partners and a mobile theatre to help reduce waiting lists for elective treatments.
- Pharmacy arrangements for discharge were seven days a week. October 2014 review demonstrated that average dispensing time was 90 minutes; the target is less than 2hours. We saw this was an improving picture from July to October. Although staff told us they waited longer for discharge medications.
- In an effort to improve the discharge process prescriptions for discharge medication should be written the day before, at the time of the inspection the trust was achieving 24% compliance with this target.
- Medical staff told us they felt pressure when they received emails exhorting them to discharge patients on a Fridays so the trust could manage the weekend admissions.
- The trust has been described as an outlier for the number of readmissions following discharge within 30 days. Within the quality account the trust demonstrated figures which was above the England average (worse), although these figures were for 2012/13. We saw in a report to the quality and risk committee (November 2014) that readmissions was still an issue and was deteriorating. The trust target is no more than 1,128 readmissions per month and in September 2014 there were 1,308 readmissions. The trust had missed all the targets from April to September 2014.

Summary of findings

- The trust recorded the number of cancelled procedures in theatres. Within day surgery we saw comparisons between 2013/14 and the current year 2014/14. April to October (seven months) the trust recorded cancellations higher than the previous year on four occasions.
- We also noted the number of patients who were waiting more than 30 minutes to return to wards following a surgical procedure. These figures were compared to the previous year and from April to October 2014 every month the number was higher (worse) than the previous year. This meant that the recovery area was congested and wards were not discharging patients quickly enough to make beds available.
- The trust recorded the numbers of patients who have had their emergency surgery cancelled more than twice within a performance summary 2014/15. The target was zero. From April to October 2014 May met the target, the other months have been below 5, but September and October was three and four respectively.
- Midwives at GHH on the postnatal ward had undertaken additional training to enable them to undertake examination of the new-borns. This initiative meant improving discharge times. They undertook 70% of the examinations in 2014 for which they did not need to wait for a medic.
- Within the minor injuries unit (SH) staff were not consistently able to triage all patients within 15 minutes and were also failing to have the final treatment plan in place by three hours after arrival and then to admit or discharge for some patients.
- Within SH AMU we were told the unit was trialling a new discharge system, the aim was to identify patients, initiate care packages quickly and discharge patients home. However, nurses found it be “exceptionally challenging”.
- The trust has set up an initiative called SAFER, which was to help them improve discharge arrangements which was one of the priorities for improvement 2013/14. One of the targets was that all patients will have a planned date for discharge (PDD) agreed within 24 hours of admission. The trust was reporting on compliance against this on a monthly basis. However we noted that the question asked was “have staff talked to you about when they expect you to be able to go home or leave hospital” not “have staff agreed your PDD within 24hrs of admission?” It appeared the trust was not measuring against the target. We also noted that the target was described as within 24hrs and within 48hrs. This could lead to confusion of what the target measure actually was.

Summary of findings

- The trust measured the number of patients who were discharged on or before their PDD this was approximately 35%. This demonstrated a congested bed base.

Learning from complaints and concerns

- Complaints received by the trust from July- September 2014 totalled 585. These included both formal and informal complaints enquiries and GP informal complaints.
- The trust had analysed the complaints received to track themes over 2014Q1 and Q2. We reviewed figures presented to the Quality and Safety committee. The top three themes related to delays and cancellations, attitudes and behaviours, and appropriate treatment.
- The complaints were further analysed by staff group. The top three being doctors, nurse and Out Patient Administration.
- Generally the figures presented compared 2014 Q1 and Q2, we saw that Q2 figures were not statistically significant. However, complaints about discharge one area had worsened in Q2 with regard to medication from 5 in Q1 to 18 in Q2.
- Another area of concern was midwifery which had more than doubled the number of complaints 2014 Q1 and Q2.
- Local resolutions worked well for both complainants and staff. AMU at BHH had evolved this further offering meetings which were recorded and the complainant took a copy home with them.
- Information taken from the trusts Quality and Risk Committee Complaints Report - November 2014 indicated doctors or medical treatment were the most complained of staff group or area. In the main patients and relatives were concerned as to whether they or their relatives had received the right or the most appropriate treatment for their condition.

Are services at this trust well-led?

Summary

The trust had a number of issues which needed to be addressed. The leadership were fully aware of the challenges ahead and had plans in place to address them. We saw that there were a many plans and initiatives in place and being drawn up. This gave the impression of a service under great flux and transition. Some of the basic steps required were not in place. Staff lacked knowledge of the trust vision and strategy, but more importantly, could not describe it for their own areas.

Requires improvement



Summary of findings

The governance arrangements needed to be strengthened, which was accepted by the leadership and we saw that some provisional work had been identified. The board were not in a position to rely on the management reports presented to it; it was felt the reason for this was IT based.

Leadership was undergoing a major transitional phase, which was having an unsettling effect on staff morale. It was clear that some staff had had experiences of a negative nature regarding leadership within middle management, and also the culture of the trust needed to improve.

Staff and public engagement was being undertaken, but both needed to improve the response rate.

Vision and strategy

- During our inspection we spoke to staff at all levels and for all departments we inspected. We found that the large majority of staff were not aware of the trust vision and strategy.
- This was corroborated by a board member and senior management we interviewed who were not surprised at staff not being able to identify a trust wide vision and value. They said more work was scheduled for this December 2014.
- We were provided with a document which laid out corporate strategy for 2014-2016. This had been approved by the Board of Directors shared with the regulator Monitor. It set out the five major objectives. These were transforming acute care, investing in out of hospital services, being recognised as providing outstanding services, developing a more distinct identity for our hospitals, and creating a truly patient centred culture.
- As part of the of 'developing a more distinct identity for our hospitals' the trust was in the consultation stage of publicising the surgery reconfiguration. Identifying how the three hospital sites would specialise. The preferred option was for instance Heartlands would undertake all thoracic surgery, Good Hope all urology and Solihull all Orthopaedics.

Governance, risk management and quality measurement

- The use of audits to measure the many aspects of the outpatient departments (incidents, complaints, responsiveness to patient needs), was not fully monitored to effect change by local management. Local management and operation staff lacked insight into their service and its ability to deliver improvement. This was despite the trust collecting audit measures. For example DNA rates Year to Date (YTD) at the time

Summary of findings

of our inspection were; new attendees 15.9% and follow-up 12.7%. This could indicate that this information was not shared with the local management and if it was they were not acting on it with operational staff to improve services.

- Notable as an exception was sexual health, infectious diseases and diagnostic services, who did use management report outcome tools to improve service delivery.
- Mandatory training rates for the trust was 80% YTD at Sept 2014, the trust target was 85% by the end of March 2015.
- We were supplied a sample of risk registers which identified the risks to the trust and what mitigating actions needed to be undertaken to reduce the risks. For example 18 week Referral to Treatment Time (RTT) was identified. The initial score rating was high at 16, but the target had not been agreed. An issue has arisen with the trusts computerised monitoring which is one of the monitoring tools for the RTT. The trust had identified other means of measurement, but would have to address the current computer system in place.
- Documents supplied to us by the trust we noted in the Finance and Performance committee November 2014 was unable to report on the RTT. The Chair of the trust pointed out how reporting was a mandatory function. He went on further to explain the reputational damage the trust could expect, and how this demonstrated serious leadership failings.
- There were three routes for booking patients into outpatients. We found that one of these routes appeared to disadvantage patients effectively resulting in them having to wait longer to receive an appointment. It also appeared that this process effectively meant there were two lists running. We were concerned that patients may be missed when they required an appointment.
- The trust had identified a patient had died whilst waiting for treatment, and during the investigation 92 other patients were waiting on the same treatment pathway. Following validation this number was reduced and the longest case had been waiting 38 weeks. The trust was taking action to increase capacity to treat the people on the list. The trust had identified this as high risk in November 2014.
- The escalation process in SH ED was still in progress as it had only just recently been implemented. However, the risks appeared not to be accurately monitored and managed to improvement. We noted that more work was required to improve the process of escalation and use of the medical assessment unit which at times was required to be a majors unit. In addition to this when this medical assessment unit was busy it overflowed into the adjoining minors unit. The trust had

Summary of findings

worked with other stakeholders such as commissioners and West Midlands Ambulance Service. The trust is waiting for the highway agencies to change the signage in the area. The trust did engage in a public consultation awareness campaign, so that local people were aware of the change of services offered.

- Management report information was not always present for the Solihull site. For many of the wards months of management information was missing from dashboards. We were aware that being able to produce reports at times has been an issue for the trust. We saw in minutes that the Chair had had to address this at committee very strongly reminding senior staff of their responsibility. This lack of information would have a detrimental effect on local leadership, because this is the information they rely upon to effect positive changes for patients.
- Staff expressed concerns regarding the IT systems. This was echoed by senior and executive staff who felt it did not support the business. At the time the leadership felt they were 5-6 months away from having full confidence in the data captured and presented.
- During our interviews of board members, one person told us, although reports of significant issues were produced, they were not routinely discussed at board meetings, such as the ED and safety breaches.
- We noted within board papers and at interview of senior staff that strategic risk register required updating to reflect the corporate strategy. In addition to this the Board Assurance Framework also needed further development. This would ensure the trust executive management board were sighted on all the issues and the control measures required addressing them.
- At the time of the inspection there was a vacancy for a Deputy Medical Director to lead on Quality and Safety. The trust was actively recruiting to the role.

Leadership of the trust

- The trust had undergone many changes within the leadership prior to our inspection. This had resulted in changes in working practices. The Executive Management Board (EMB) previously met monthly, at the time of our inspection they were meeting weekly. It was felt this was required to meet the challenges the trust was facing.
- The Non-Executive Directors (NED) were not previously providing effective challenge, which had been identified in an external report. Although it was reported that all the NEDs were

Summary of findings

in their first term. A Board development plan was required. The Chair had made changes so that the NEDS were better informed and were able to contribute to board meetings more readily.

- Board members were sighted on the patient flow issues within the trust.
- The Chair ensured he spent time within departments to better understand what worked well and not so well within the trust. There was admission that further work needed to be undertaken to ensure the three sites worked cohesively.
- Staff told us that local leadership was good but above that it became difficult, the Chair corroborated this. We saw that the management layers could be seen as confusing and complicated.
- The Chief Executive Officer was interim at the time of the inspection and had only been in post a matter of weeks. Along with many others within the leadership. It was clear that there was a good understanding of the issues within the trust. He understood that the change could be unsettling for staff. Therefore along with the Chief Nurse and the Interim Medical Director had undertaken open engagement meetings with staff to inform them of the changes.
- The CEO had engaged with other stakeholders very openly to keep them informed of the changes and plans.
- Along with other stakeholder advice the trust board was open to working with other trust to support them to achieve an improved position.
- The Sexual health clinic for all areas we inspected appeared to be safe, responsive and well led.
- Annual staff appraisals had not been conducted for all staff. Nurses told us appraisals were rushed and they were linked to the pay incremental process. This meant if staff did not receive an annual appraisal, there was a risk they will not receive a pay rise.
- Within focus groups staff told us of there being an impression that all decisions came from BHH, and there was a lack of visibility of managers who appeared to spend more time at trust headquarters than on the other sites.
- The visibility of senior managers within the maternity service was an area of concern at our last inspection November 2013. The trust produced an action plan to improve. All action on the plan remained ongoing. However, during this inspection we found that the matter had not been improved. When we shared this with the Head of Midwifery, they responded by arranging a meeting with all Band 7 nurses. According to the action plan this meeting was already supposed to take place every week.

Summary of findings

- The visibility of the management within outpatients department was also an issue to staff. The management had to cover all three sites.
- Student midwives wanted substantive roles within the trust because they felt the preceptorship programme was very good.

Culture within the trust

- The trust was in a transition phase, there had been many changes of leadership. The culture of an organisation emanates from the leadership. The staff we spoke to talked about a management style that was not inclusive and gave many examples of that. However most were aware that changes had happened so the overriding culture at the time was one of uncertainty.
- Leadership within the organisation understood that values and cultures needed to change.
- Operational staff felt decisions were taken with little consultation.
- We received feedback that indicated that some middle managers were not supportive of the operational staff issues. We heard this from staff on all sites and from many professions. They articulated their frustration and some became visibly upset. The result was some staff disengaged from wider responsibilities and concentrated solely on their own work.
- There was a “live” issue with some Band 7 staff who had written to a member of the executive team raising their concerns about patient safety. During our inspection these staff were invited to meet with the executive and HR. A process of resolution dialogue was commenced. It was not concluded during the inspection.
- Senior staff told us that the reconfiguration of surgery presented an issue for some staff. For instance some staff who had worked in GHH for many years believed they work for GHH not the trust. At focus groups not all staff were happy to move to other sites, their biggest concern was about travelling.
- One board member said that the trust historically micro-managed staff and that the board needed to think more ambitiously about what could be achieved.
- Another board member talked about the culture being more medically led, but the appointment of the Chief Nurse was having an impact on that, by raising the profile of nurses. Staff during a focus group gave an account of a long standing issue which when the Chief Nurse was made aware of it and it was quickly resolved.

Summary of findings

- We were aware that the culture displayed by the new leadership was beginning to change perceptions in the trust, but this was early days to see this as sustainable.
- The treatment of whistle-blowers is an area which the trust had worked on. They had produced a policy which was promoted within the trust. However, there remained a lack of trust amongst the staff group about how they would be treated if they raised concerns. The trust leadership needed to do more work to ensure staff understood there was a no blame culture for legitimate concerns. One of the senior leadership team agreed this was an issue where more work needed to be undertaken.

Public and staff engagement

- Friends and family tests (FFT) are undertaken within the trust. We were supplied with results, the trust has a CQUIN to improve the response rate. The trust had achieved the target for October 2014 at 38% for inpatients & 17% for A+E.
- At the time of our inspection the national staff survey was being undertaken. The previous year 32% of staff completed the questionnaire. The trust have been encouraging staff to complete it and set a target of 50%.
- From the 2014 data it showed staff engagement was marginally worse than in 2013; but this difference between the two years was small. Nonetheless; the trust performed below the national average.
- From the 2014 national NHS Staff Survey, the trust performed below the England average in 23 of the 29 questions; and of these they were in the bottom 20% of the country in 11 of these questions. This included “Staff recommendation of the trust as a place to work or receive treatment” and “reporting good communication between senior management and staff”. We saw that a leaflet had been produced which summarised some of the staff issues which arose as a result of the staff survey. They echoed the feelings of staff shared with us during the inspection.

Innovation, improvement and sustainability

- The priorities for improvement identified for 2013/14, of which there were seven, have remained in place for 2014/15. This was to enable the trust to continue to develop quality and compare progress.

Summary of findings

- One of the executive team at interview informed us that there was a plan to attract and retain more senior nurses to the trust. It involved Advanced Nurse practitioners having a clear development pathway that would result in them becoming Nurse Consultants.

Overview of ratings

Our ratings for Birmingham Heartlands Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	N/A	N/A	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Surgery	Not rated	N/A	N/A	Not rated	Not rated	Not rated
Maternity and gynaecology	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement

Our ratings for Good Hope Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Surgery	Not rated	N/A	N/A	Not rated	Not rated	Not rated
Maternity and gynaecology	Requires improvement	N/A	N/A	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Solihull Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement
Surgery	Not rated	N/A	N/A	Not rated	Not rated	Not rated
Maternity and gynaecology	Requires improvement	N/A	N/A	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	N/A	N/A	Good	Requires improvement	Good
Overall	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement

Our ratings for Heart of England NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	N/A	N/A	Requires improvement	Requires improvement	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

- On AMU at Birmingham Heartlands Hospital local complaints resolution was very responsive to patient's needs. The complainant was invited to a meeting and given a recording of the discussion. This appeared to resolve complaints quickly.
- AMU, Ambulatory Care, wards 10, 11 and 24 provided excellent local leadership, services were well organised, responsive to patients individual needs and efficient which resulted in excellent patient outcomes.
- The Practice Placement team provided excellent links between the trust and the University in supporting more than 600 student nurses across all three hospital sites.
- Sexual health team demonstrated how they used information such as audit and patient feedback to improve services to patients.

Areas for improvement

Action the trust MUST take to improve Birmingham Heartlands Hospital

- The trust must address the ambivalence held by staff about reporting incidents as they may be underreporting and trust could miss important trends.
- The trust must take effective action to achieve consistent staff compliance of infection control procedures.
- The trust must ensure that all staff receives appraisals to support clinical delivery and continually improve skills and improve patient outcomes.

ED

- The trust must ensure that staff are clear about clinical responsibility for patient's awaiting handover by Ambulance services.
- The trust must take effective action to address the crowding in the majors area of the ED department and ensure that staff on duty can see and treat patients in a timely way.

Medicine

- The trust must ensure all patients requiring items of restraint such as hand control padded mittens are supported with a mental capacity assessment, a DoLS and are regularly reviewed by the MDT which is recorded in the patient's notes and mittens are replaced when soiled. A consistent practice must be adopted across the trust.

Surgery

- The trust must improve arrangements regarding patients following surgery having to wait in recovery over 30 minutes.

Maternity

- The trust must provide sufficient staff to operate the second obstetrics theatre at night, and prevent delays occurring.
- The trust must ensure that emergency medicines are readily available, stored and in date for use in such situations.

OPD

- The hospital must improve the information available to departments to ensure that these are monitored and action taken to improve services through audit, trending and learning.

Good Hope Hospital

- The trust must ensure that all staff receives appraisals to support clinical delivery and continually improve skills and improve patient outcomes.

ED

- The trust must take effective action to address the overcrowding in the majors area of the ED department and ensure that staff on duty can see and treat patients in a timely way.
- The trust must review the operation of rapid assessment of patients to improve its consistency and effectiveness.

Outstanding practice and areas for improvement

- The trust must take effective action to achieve consistent staff compliance of infection control procedures

Medicine

- The trust must ensure all patients requiring items of restraint such as hand control padded mittens are supported with a mental capacity assessment, a DoLS and are regularly reviewed by the MDT which is recorded in the patient's notes and mittens are replaced when soiled. A consistent practice must be adopted across the trust.

Surgery

- Improve the environment of the transfer corridor used to transport patients and dispose of refuse appropriately.

Maternity

- The trust must provide sufficient staff to operate the second obstetrics theatre at night, and prevent delays occurring.

OPD

- The hospital must improve the information available to departments to ensure that these are monitored and action taken to improve services through audit, trending and learning.
- The hospital must take steps to improve adherence to infection control processes to ensure the safety of patients. This includes the monitoring of hand washing practices and the bare below elbows policies.

Solihull Hospital

- The trust must ensure that all staff receives appraisals to support clinical delivery and continually improve skills and improve patient outcomes.

Medicine

- The trust must ensure patients are not labelled with a condition unless a diagnosis has been confirmed by a medic.

Surgery

- The trust must improve arrangements regarding patients following surgery having to wait in recovery over 30 minutes.
- The trust must replace or repair essential equipment in a timely manner.

Maternity

- The trust must ensure that emergency medicines are readily available, stored and in date for use in such situations.

OPD

- The hospital must improve the information available to departments to ensure that these are monitored and action taken to improve services through audit, trending and learning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(2)(b)(f) Lack of robust incident reporting and feedback which could result in learning opportunities lost. Management of patient handover, overcrowding and timely assessments undertaken in ED Patients waiting over 30 minutes in recovery Service delivery and improvement in OPD with the use of management reporting data.
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(g)(h) Where emergency medications were required within maternity they were not readily available, staff were unaware of its whereabouts and they had not been checked regularly to ensure they were still in date and safe to use. Within ED cleaning practices needed to improve. Within the trust staff were not adhering to the trust policy.
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15(1)(f) Lack of equipment and faulty equipment not being replaced in a timely fashion.

This section is primarily information for the provider

Requirement notices

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulated activity

Diagnostic and screening procedures

Maternity and midwifery services

Nursing care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

13 (4)(b) (5)

Safeguarding processes were not in place for people wearing mittens within the trust.

Regulated activity

Diagnostic and screening procedures

Maternity and midwifery services

Nursing care

Surgical procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

18(1)(2)(a)

Nursing staffing was insufficient in places having a direct impact on patients. For instance not being able to staff the second obstetrics theatre in maternity.

The appraisal rate for staff within the trust was at 38%. This rate had the potential to impact on the level of care patients received. Manager also lost the opportunity to support staff and identify areas where additional support was required.

In addition the visibility of the head of midwifery continues to be an issue as identified during our previous inspection November 2013.