Heart of England NHS Foundation Trust

Solihull Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. 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 hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Not sufficient evidence to rate
Maternity and gynaecology	Requires improvement
Outpatients and diagnostic imaging	Good

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.

This inspection was an unannounced responsive inspection and as such we will not be rating the service. 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 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.

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.
- Staffing sickness and attrition rates were impacting negatively on existing staff.
- The congestion within the hospital 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.
- 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 many in interim posts.
- 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 reporting needed to be improved to ensure reporting was accurate.

We saw several areas of outstanding practice including:

- Areas of good practice related to the AMU short stay senior sister who had been recognised as a ‘leading light’ for Compassion in Care.
- 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.

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

- Feedback from incidents and learning from them needed to improve for staff and patient outcomes.

Importantly, the trust must:

- The trust must ensure all fire doors and exits are free from clutter.

Summary of findings

- 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.
- 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.

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

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We found that emergency services at Solihull Hospital were safe but required some improvement. Incidents were reported by staff but not all staff were confident that the department learned from when things went wrong. The emergency department (ED) relied heavily including overnight, on locum doctors who were not permanently employed by the trust. They may not all have the necessary skills and experience to deal with some types of emergency that could come in. Consultants were dual qualified in emergency with children's medicine and also worked in the busy ED's at the trusts other hospitals where very sick children were treated. Nurses specialised in emergency medicine. The procedures to cope with a higher number of patients attending than the unit could safely manage did not properly support staff to cope. Emergency services at Solihull Hospital were responsive but could improve. The ED was open 24 hours a day and seven days a week and was valued by local people. It provided only a minor injuries unit and it was confusing to the public what other emergencies it could deal with and how. The trust was in consultation with local people and primary health care providers such as GP's about changing the services to what the local population, especially the growing number of older people needed. The ED leadership at local level was good and staff were aware of the vision and future plans for the service. Some of the management arrangements from the higher level within the trust could improve however. This would better support the

Summary of findings

specific needs of Solihull Hospital ED particularly around how to help the hospital respond safely when it was very busy.

Medical care	**Requires improvement**		Medical services at Solihull Hospital required improvement despite the fact that care was delivered by caring, dedicated and compassionate staff. Incident feedback for staff was poor and safety thermometer incidents had steadily increased over the last three months. Staff had not attended all mandatory training. Environmental issues and lack of appropriate facilities was a concern for AMU short stay and AMU ground floor services and lack or privacy and confidentiality was an issue at AMU ground floor services. Completion of risks assessments and responding to patient risks required improvement across some medical wards. Nurse staffing levels and appropriate skill mix was problematic across all medical wards and the ability to safely discharge patients in a timely manner was a concern. Staff did not feel involved in decisions about the wards they worked in. Local level leadership was supportive and nurturing, however communication and support from middle management and executive level was described as; forceful and aggressive. Support from the Practice Placement team for student nurses was recognised by all staff as exceptional and individual nursing practice at the AMU short stay had been recognised by the trust as excellent practice.
Surgery	**Not sufficient evidence to rate**		Staff rarely received feedback on lessons learnt following reported incidents. Equipment was not stored appropriately causing trip hazards and faulty machinery was not repaired in a timely manner. The World Health Organisation (WHO) checklist

Summary of findings

was not always done in the anaesthetic room. Data was input to an IPAD later, which could lead to potential errors of recording.
There were delays in theatre due to staff shortages on the wards resulting in delays of up to an hour per day. Theatre staff said there was an issue with not having interpreters available, resulting in many operations being delayed or cancelled.
Staff on one of the surgical wards told us they had never seen the executive team but knew the senior site team. Theatre staff said they, “Felt left out of the loop, isolated and unwanted.”

Maternity and gynaecology

Requires improvement

The Netherbrook birth unit was appropriately staffed with a good skill mix. The checking of emergency equipment needed to be improved and arrangements for evacuating women from the birth pool. The unit would have benefitted from more staff involvement in future service provision. However, the service was flexible in catering to women’s needs and accommodated partners.
Good local leadership was displayed and was staffed by a motivated team who supported and welcomed midwives who rotated into the unit.

Outpatients and diagnostic imaging

Good

The outpatient department at Solihull Hospital were safe, and responsive to patient’s needs. Whilst there was a lack of performance data to enhance services local staff had taken the initiative and addressed the issues raised by patients at the hospital. An example of this was the introduction of an efficient system for seeing patients who arrived on stretchers via ambulance. The hospital utilised the services of a large body of volunteers to assist the department and to ensure that patients were seen in an efficient manner.
Patients we spoke with were very satisfied with the service provided and stated that care and medical staff had time to talk them through their care and treatment.

Summary of findings

There was plenty of information available to patients both in written form and verbally on their care and treatment. The environment was pleasant and patients did not experience delays in treatment.

Solihull Hospital

Detailed findings

Services we looked at

<Delete services if not inspected> Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Solihull Hospital

Solihull Hospital and Community Services (we did not inspect the community services) includes both a hospital site with approximately 200 beds and Community Services serving the Solihull population of approximately 220,000 people. It also provides some services to the whole of the Trust's catchment area. Solihull is an affluent suburb of Birmingham that retains its own identity as a town. Based near to Solihull town centre, Solihull Hospital provides a range of outpatient, inpatient and some emergency care services for its local community. It is also the regional centre for dermatology (the treatment of skin conditions).

Trust wide information.

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

This trust is a Foundation Trust which means it is a not-for-profit, public benefit corporation. It is part of the NHS and provide 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.

Detailed findings

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 five of our eight core services and also looked at trust wide leadership. We visited

- Emergency Department (A&E)
- 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.

Facts and data about Solihull Hospital

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.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	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

Urgent and emergency services

Safe	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The emergency medicine directorate covers services at three hospital sites within the trust, Birmingham Heartlands Hospital, Good Hope Hospital at Sutton Coldfield and Solihull Hospital. Approximately 250,000 people attend the trusts' emergency departments each year.

The emergency department (ED) at Solihull Hospital does not receive ambulance-borne trauma cases and has no facilities for the treatment of paediatrics on site. It receives only patients with minor injuries and minor illness.Patients with major trauma (such as fractured hip bone) or very sick children are directed to go to Heartlands Hospital or Good Hope Hospital (depending on proximity) which are also part of the trust.Patients with major medical illness, such as heart attack or stroke will be directed to the medical assessment unit (MAU) which is co-located to the emergency department. The MAU attends directly to seriously ill patients with medical problems, but not surgical, trauma, children, gynaecological or labour problems.

During 2013/14, the hospital site covered 44,588 emergency department attendances and 6,562 emergency spells of admission to hospital. Emergency department attendances had risen from close to 36,000 during 2012/13.

We visited the hospital unannounced on 11 December 2014. We spoke with five patients and their relatives and with six staff in a variety of roles including from West Midlands Ambulance Service. We observed the care provided to patient's.

This visit was undertaken in response to concerns and to follow up on requirements we made for improvements at our last inspection of the hospital in November 2013. We found in November 2013 that as a minor injuries unit (MIU), it was safely resourced and run. However, it did not have the resources of an emergency department. The unit had medical cover from 8am to 8pm, after which cover was provided by an on-call system. However, there was significant potential for major trauma patients to arrive as patients walk in to the emergency department. These patients would then be stabilised and sent to a trauma centre. Staff reported that, at times, trolley patients overflowed from the acute MAU (Medical Assessment Unit) into the ED minor unit where they would be looked after by the nursing staff on this unit. The trust needed to address the confusion about the services it provided in respect of emergency care and treatment. Following the inspection the trust made us aware that when a patient who had walked into minor injuries but subsequently been identified for the MAU; medical staff would sometimes see patients in the MIU rather than wait for a cubicle in MAU.

The unit treated up to 10,000 children a year, there was one nurse with specific training in providing care to children employed within the unit. Medical paediatric cover was provided from Heartlands Hospital.

The site commenced an Urgent Care Review in spring 2014, led by Solihull CCG, with four key aims. These were to ensure Solihull would have a long term urgent care service that would be sustainable, provide more "joined up" working; a safer "less confusing" service and increased access to walk-in services for patients. The Review was completed in April 2014 and its recommendations were to be

implemented and continue grow and be embedded over the following 12 months.

Urgent and emergency services

Summary of findings

We found that emergency services at Solihull Hospital were safe but required some improvement. Incidents were reported by staff but not all staff were confident that the department learned from when things went wrong.

The emergency department (ED) relied heavily including overnight, on locum doctors who were not permanently employed by the trust. They may not all have the necessary skills and experience to deal with some types of emergency that could come in. Consultants were dual qualified in emergency with children's medicine and also worked in the busy ED's at the trusts other hospitals where very sick children were treated. Nurses specialised in emergency medicine. The procedures to cope with a higher number of patients attending than the unit could safely manage did not properly support staff to cope.

Emergency services at Solihull Hospital were responsive but could improve. The ED was open 24 hours a day and seven days a week and was valued by local people. It provided only a minor injuries unit and it was confusing to the public what other emergencies it could deal with and how.

The trust was in consultation with local people and primary health care providers such as GP's about changing the services to what the local population, especially the growing number of older people needed.

The ED leadership at local level was good and staff were aware of the vision and future plans for the service. Some of the management arrangements from the higher level within the trust could improve however. This would better support the specific needs of Solihull Hospital ED particularly around how to help the hospital respond safely when it was very busy.

Are urgent and emergency services safe?

Requires improvement

Summary

Emergency services at Solihull Hospital were required improvement as some processes were not robust enough. Incidents were reported up through the trust and there were some systems in place at local level to learn from them. Not all staff were confident that this learning was effective however.

The department was clean, tidy and well-ordered and the majority of staff followed the trust hygiene policy. The paediatrics waiting area was not well designed and children could be seen by the adults waiting to be seen.

Consultants were dual accredited in emergency with paediatrics medicine and also worked in the busy ED's at the trusts other hospitals where very sick children were treated. The ED relied heavily on regular locum doctors and overnight locum registrars may not always be appropriately experienced to respond to some emergencies that could present in the ED. Nurses were emergency nurse practitioners or advanced clinical practitioners.

Escalation procedures to cope with a higher number of patients attending than the unit could safely cope with; depended on capacity within the adjacent medical assessment unit which itself was frequently crowded. The escalation procedures were not effective and did not adequately support the emergency department.

Incidents

- Staff told us that the there was a good culture of incident reporting in the department but were less sure of whether there was an effective system for learning from incidents.
- Local leaders referred to the good quality of a 'Risky Business' publication produced by the trust wide consultant lead for ED risk, but were not confident that it was widely read.
- Although medical staff were confident about the system in place which identified locums that lacked the skills and experience required, they were unclear about whether these issues were reported as incidents.

- Medical staff told us that 'very good' consultant led monthly meetings were held to discuss incidents and these were compulsory for non-training staff except locums.

Cleanliness, infection control and hygiene

- The department was clean, tidy and well ordered.
- Staff followed the trust hygiene policy of being bare below the elbow and we noted that they regularly cleansed their hands.
- When we visited the adjacent MAU we noted a consultant in the clinical areas wearing a suit and tie although junior doctors accompanying were following the trust policy.

Safeguarding

- The trust had met its target for safeguarding adults level 2 training which was 85%. This figure is not specific to Solihull emergency department.
- Staff had access to an up to date safeguarding policy via the intranet.
- Staff were supported by safeguarding leads who could be contacted for support.

Environment and equipment

- The clinical environment was generally safe, contemporary in layout and uncluttered. There were curtained cubicles and cubicles with doors that provided more privacy and an infection isolation capability. At the time of our visit it was not busy but staff told us, 'Solihull is good until it becomes busy'.
- There was a paediatrics waiting area adjacent and open to the adult's inner waiting area. Children had to pass through the adult's area to get to it. The design meant that children would also be exposed to any inappropriate or upsetting behaviour from waiting adults, while in the paediatric area.
- Three well equipped resuscitation bays were in the adjacent medical assessment unit (MAU) including a paediatric bay. There was a good stock of appropriate, within date equipment including resuscitation trollies.

Medicines

- The resuscitation drugs box medications were in date and drugs were stored in a locked cupboard in the resuscitation area.

Assessing and responding to patient risk

- Patients who arrived on foot booked in at the main reception area of the ED and the minor injuries unit nurses aimed to assess them within 15 minutes. Paediatric patients are immediately directed into the paediatrics' waiting area. Patients referred by their GP were directed to the MAU.
- Ambulance crews booked in their patients to the MAU.
- Doctors told us that there was a risk of the department being unable to respond to an acutely ill child or a patient presenting with a surgical emergency but added that this was a risk for all Minor Injuries Units (MIU).
- The clinical director told us that an additional shift each day had been acquired for the MIU in order to provide a nurse who would concentrate on assessing patients within 15 minutes of when they arrived, but that it was not always covered.
- We noted that a paediatric patient with an ankle injury waited for an hour before being assessed. We were told there was no assessment nurse on duty at that time.
- Patients whose condition deteriorated while they were in the MIU were taken to the adjacent MAU.
- For individual patients the MIU aimed to have a final treatment plan in place by three hours after arrival and then to admit or discharge the patient.
- Staff in the MAU told us that they try to assist the MIU with its national four hour target to see, treat and discharge or admit 95% of patients within four hours of arrival, by taking patients close to breach into the MAU.
- During our visit the MAU was very busy and crowded and staff told us this was not unusual. Nursing staff said the MAU escalation procedure was to contact a consultant if they were overwhelmed in order to find more doctors during 9am to 5pm, 'If we have to escalate to the site team, and some days get no support, the team feels we have nowhere to go.' The view was that some ownership of the problem was being taken by the trust more recently and senior nurses tried to ensure they attended hospital bed meetings to influence this.
- A trust wide ED escalation standard operating procedure was about to be introduced at the time of our visit. We noted however that this did not address the specific situation at Solihull Hospital where the ED was functioning only as a minor injuries unit and dependant on a medical assessment unit to double as a partial major's stream when necessary.

Nursing staffing

- The minor's injury unit was staffed by Advanced Nurse Practitioners (ANP) and Emergency Nurse Practitioners (ENP).

Urgent and emergency services

- There were 25 ANP's in the trust working across all three hospital sites. At Solihull ED one ANP was on duty for each shift (with some overlap) and two ENP's. One nurse was on duty overnight.
- The clinical director for emergency medicine confirmed that all staff had paediatric training.

Medical staffing

- The clinical director confirmed that the Solihull ED relied on regular locums and consultants worked across all three hospital sites.
- Solihull ED had registrar cover 24 hours each day for seven days a week. At the time of our visit consultant cover was between 9am and 5pm weekdays but it was the intention of the trust to change this pattern to 9am to 1pm seven days a week.
- Overnight locum registrars may not always be appropriately skilled to respond to some emergencies that the ED could be presented with.
- Three consultants were dual accredited in emergency with paediatrics medicine. The clinical director expressed confidence in their competence. He told us they did rotations across the other two hospitals ED units within the trust where there was a training repository for paediatrics and they got regular experience of treating very sick children.

Major incident awareness

A major incidents grab bag was available, visible, packed, and ready for use. A room off the main reception area was clearly signed as the majors incidents control room.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Summary

Emergency services at Solihull Hospital were responsive but could improve. The trust was in consultation with local people and primary health care stakeholders about reconfiguration of the services. However confusion about the services it provided in respect of emergency care and treatment remained.

The ED was open 24 hours a day and seven days a week and was valued by local people. It provided a minor injuries unit. The medical assessment unit within the hospital and adjacent to the minor injuries unit took GP referrals and received only some types of ambulance arrivals (MAU only). However there was some overlap between these different functions in the hospital particularly in periods of heavy demand and this was confusing.

The trust had taken action to ensure that patients were assessed within 15 minutes of arriving at the department but these arrangements did not always work and some people had long waits to be seen by a nurse.

Service planning and delivery to meet the needs of local people

- The trust website reported that the Solihull Hospital site commenced an Urgent Care Review in spring 2014, led by Solihull CCG, with four key aims. These were to ensure Solihull would have a long term urgent care service that would be sustainable, provide more "joined up" working; a safer "less confusing" service and increased access to walk-in services for patients. The Review was completed in April 2014 and its recommendations were to be implemented and will continue to grow and be embedded over the next 12 months.
- The trust wide website emergency medicine page for Solihull Hospital referred to the MAU at Solihull hospital as the Majors Assessment Unit. We were told this was an error, but it added to the confusion about what Solihull ED actually offered.
- We noted that there was a walk in out of hours GP service on site
- Four out of the five patients that we spoke with told us they had made a decision to come to the hospital rather than go to their GP.
- The clinical director for emergency medicine across all three hospital sites in the trust told us that the hospital had undertaken work in the local area to dissuade parents from bringing very sick children to Solihull Hospital.

Meeting people's individual needs

- There was no written information or signing available to people who did not speak English.

Urgent and emergency services

- Parents with children told us they were given no update or plan for their child's assessment or treatment and they were frustrated at 'hanging around' with three small children.
- Patients were provided with little information about waiting times or their position in the queue. One patient told us that reception staff had not been helpful.
- The trust was piloting a project in some of its other hospitals involving an 'about me' booklet to better support people living with dementia when they were admitted to wards. We saw no particular system for supporting patients living with dementia or learning disabilities through the trusts ED sites including at Solihull.
- Staff in Solihull ED confirmed there was a system whereby a 'bug' symbol was put on a patient's electronic record to alert staff that they were particularly vulnerable or could be a challenge to staff safety.
- We looked at a sample patient record with a 'bug' on it. Staff were however not able to identify from the record what the 'bug' related to for this person, this suggested it was an ineffective system.
- The trust had an easy read accessible version booklet that encouraged people to comment on services and to use the complaints procedure.

Access and flow

- The ED at Solihull Hospital was open 24 hours a day and seven days a week.
- It provided a minor injuries unit (MIU). The medical assessment unit (MAU) which was adjacent, and took GP referrals, received some types of ambulance arrivals.
- Staff told us that ambulance crews took only patient's with certain conditions to the MAU.
- Most patients walked in and were assessed by the minor's injury unit team. If patient's arrived 'by blue light', staff said the adjacent MAU responded to this and 'turned themselves in to a Majors Unit as they had resuscitation facilities'.
- We spoke with West Midlands Ambulance Service staff in the MAU unit who confirmed an ambulance control directive not to take trauma patients to Solihull Hospital ED.
- The clinical director confirmed that Solihull Hospital was a 'walk in centre Plus' and not functioning as an emergency department, but 'we can manage whatever comes if we have to. Nothing comes paediatrically from the ambulance service, if it did we would stabilise the patient and transfer if necessary'.
- Paediatric patients were immediately directed by reception staff into the paediatric waiting area in the minor injuries unit.
- Staff in the adjacent MAU told us that they assisted the MIU with meeting the national four hour target to see, treat and discharge or admit 95% of patients with four hours of arrival. When we visited the MAU we noted that it was extremely busy with patients on trollies and in chairs waiting in the corridor including, still in the care of ambulance crew.
- On occasions when the MAU was crowded patients overflowed into the MIU where they were overseen by MAU doctors and MIU nurses. Following the inspection the trust made us aware that when a patient who had walked into minor injuries but subsequently been identified for the MAU; medical staff would sometimes see patients in the MIU rather than wait for a cubicle in MAU.
- Staff in the MIU told us there had been one breach of the 4 hour target in the twelve hours before our visit and none in the 24 hours preceding that out of 92 attendances.
- The MIU aimed to have a final treatment plan in place by three hours after arrival and then to admit or discharge the patient. We noted during our visit that two of the four patients we spoke with had been waiting over three hours and said they did not have information about a treatment plan.

Learning from complaints and concerns

- Parents of a paediatric patient expressed their frustration to us about 'hanging around' for hours with three small children without being given any information on the process or assessment and treatment plan for their injured child. However they said they didn't want to make a fuss, it was their local hospital and they valued it.
- Emergency department questionnaires were visibly available to patients to complete. We noted however that a 'You said, We did' display on the wall provided by the trust to engage patients, had fallen into disuse.
- Complaints were monitored for trends but this was at a trust wide level.

Urgent and emergency services

Are urgent and emergency services well-led?

Requires improvement

Summary

The ED leadership at local level was good and staff were aware of the vision and strategy for the service. However some trust wide governance arrangements could improve to better support the specific needs of Solihull Hospital ED. The ED was practitioner led.

The trust was in the process of engagement with the local community over the reconfiguration of the services at Solihull Hospital. Systems in place for gathering feedback at the point of contact from patients were not being maintained by ED staff.

Vision and strategy for this service

- The services provided by Solihull Hospital were being reconfigured and the trust was in on-going consultation with the local community about this. The clinical director expressed the vision of the trust as being to develop an extended primary care function. The Solihull Hospital ED no longer provided for trauma, paediatrics or surgery. The MIU continued to function and was practitioner led. The trust remained in contact with the local authority to remove road traffic signs that indicated an emergency department at the Hospital.

Governance, risk management and quality measurement

- There was a consultant lead for risk within the emergency directorate trust wide across all three hospital sites. They produced periodic information and briefings for practitioners on identified clinical risks that arose within the department. The department trust wide operated a risk register and this included the risk of a child with a deteriorating condition attending at Solihull MIU.
- The trust had produced an action plan dated November 2014 and compliance check to respond to improvements required for the emergency directorate services by the CQC inspection of November 2013/ January 2014. We noted that this action plan did not include the ED services at Solihull Hospital.
- The trust escalation procedure did not in practice effectively support the ED at Solihull hospital. The new standard operating procedure for ED escalation did not address the particular needs of the ED arrangement at Solihull Hospital.

Leadership of service

- The MIU was practitioner led by rotating ANP's and rotating consultants. The clinical director who worked across all three hospital sites within the trust told us that the trust had good programmes for advanced clinical practitioners trust wide to facilitate this model of working. Cross site working was well organised to meet the needs of the Solihull MIU.

Culture within the service

- Senior nursing staff told us that the ineffective escalation procedure through ED and the MAU made staff feel like their service was the 'poor relation' of the trust.

Public and staff engagement

- The trust was in the process of engagement with the local community over the reconfiguration of the services at Solihull Hospital.
- A visual installation system had been set up by the trust including within the Solihull Hospital ED to encourage and collect family and friend test comments. However we noted these displays were not being updated by the ED staff and therefore provided no information to people.

Medical care (including older people's care)

Safe	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

We reviewed the Solihull medical care service on the 11 December 2014 and visited medical care wards and wards where patients had medical needs were staying, these included; wards 14, 17, 18, 19, AMU ground floor and AMU short stay first floor. We talked to 15 patients and 27 staff members to include: health care assistants, nurses, senior ward sisters, ward managers and managers, doctors and consultants.

Summary of findings

Further improvements were required across medical services at Solihull Hospital, despite the fact that care was delivered by caring, dedicated and compassionate staff.

Incident feedback for staff was poor and safety thermometer incidents were a mixed picture. Staff had not attended all mandatory training.

Environmental issues and lack of appropriate facilities was a concern for AMU short stay and AMU ground floor services and lack or privacy and confidentiality was an issue at AMU ground floor services.

Completion of risks assessments and responding to patient risks required improvement across some medical wards.

Nurse staffing levels and appropriate skill mix was problematic across all medical wards and the ability to safely discharge patients in a timely manner was a concern.

Staff did not feel involved in decisions about the wards they worked in. Local level leadership was supportive and nurturing, however communication and support from middle management and executive level was described as; forceful and aggressive.

Support from the Practice Placement team for student nurses was recognised by all staff as exceptional and individual nursing practice at the AMU short stay had been recognised by the trust as excellent practice.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Summary

Medical services at Solihull required improvement. Staff reported incidents but received limited feedback to learn from lessons.

A decrease in performance in all four safety thermometer audits over the last three months meant patients safety was an issue. Infection control across medical wards was satisfactory. However, patient documentation and responding to patient risks was a concern. Staffing levels across medical wards was safe, but heavily supported by bank and agency staff who were not always familiar with operation of the wards and individual patient needs. Cramped and cluttered ward environment at wards 17, 18, 19, and both AMU services increased the risk of unsafe provision of care. Lack of privacy and confidentiality issues proved a continual concern at AMU ground floor service. Local leadership was good; however further improvements were required for middle management and executive leadership required improvement.

Incidents

- There were systems for reporting actual and near miss incidents across the medicine division and staff reported patient related incidents.
- Staff told us they did not report poor staffing level incidents as this was particularly difficult as the incident reporting system options were not straightforward. Staff told us this discouraged staff to report staffing concerns electronically. In many cases only verbal concerns were raised and there was no audit trail.
- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There had been no (zero) reported never events within the last 12 months across medical wards.
- Learning from incidents and obtaining feedback from senior colleagues did not occur in a structured and timely manner and staff told us they rarely received feedback or had opportunities to discuss lessons learned due to time constraints. The trust collected incident data, RCA for SI's were completed by matrons, however there was minimal dissemination of lessons learned to front line staff.
- The Trust monitor 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. However two ward sisters were unaware of the mortality folder on their respective wards and told us they did not know what it was for or what happened to the data collected.
- Doctors told us mortality reviews were carried out monthly without nursing input. Doctor's felt nursing input wold have made the review more meaningful.

Safety thermometer

- Results of the safety thermometer were displayed on every ward and area we visited to include pressure ulcers, falls, VTE (venous thromboembolism) and CAUTI (catheter acquired urinary tract infections). The results related to that individual ward or area and showed comparison with results for the previous month.
- AMU short stay and ward 19 reported a similar picture and showed a small increase in avoidable pressure ulcers from July 2014 and a decrease from September 2014. Both wards reported zero falls with injuries for the past 12 months. Ward 18 showed an increase in avoidable pressure ulcers and falls with injury from September 2014

Cleanliness, infection control and hygiene

- The wards we inspected were clean.
- All staff were aware of current infection prevention and control guidelines.
- There were sufficient hand wash sinks and hand gel. Hand towel and soap dispensers were adequately stocked.
- We observed staff consistently following hand hygiene practice and 'bare below the elbow' guidance. Aprons and gloves were readily available in all areas.
- Side rooms were used where possible as isolation rooms for patients identified as an increased infection control risk (for example patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.

Medical care (including older people's care)

- All wards carried out a monthly audit which looked at infection control procedures such as commode cleanliness. Results were displayed on the ward corridor and we saw action plans in place for wards who had not met the standard.
- Ward 20a had been closed due to Norovirus, this had reopened on the day of the inspection, but not included as part of the inspection.

Environment and equipment

- The wards and areas we visited were well maintained. However, some wards such as ward 19 had its fire doors blocked with equipment. AMU short stay unit, wards 17 and 18 had insufficient storage areas which led to equipment being stored inappropriately in offices, bathrooms and around the nursing station. This made the area cluttered and it was difficult for patients, staff and visitors to move freely around the ward.
- We checked the resuscitation equipment on all of the wards we visited and found that it had been checked regularly and all equipment was in date, appropriately packaged and ready for use.
- Where identified, pressure relieving mattresses were used in the prevention and management of pressure ulcers. The trust had a central equipment bank for pressure relieving equipment and an effective process for issuing, returning and cleaning the equipment.
- The AMU short stay ward had no ECG machine; this had broken down two months previous. The ward sister told us a new one had been ordered in the meantime they borrowed another ECG machine from other areas. We were told this did not delay patient care but it meant staff were sent off the ward to collect and return it.
- The AMU ground floor was cramped with very little space in between 13 cubicles which surrounded the nursing station.
- Due to lack of space patient assessments were sometimes conducted in admin offices or in the patient bereavement room, neither were fit for purpose to carry out clinical examinations.
- We saw patient confidential information was routinely overheard at the nursing station and patient's conditions were openly discussed and overheard by other patients as the nursing station was located at close proximity to 13 assessment cubicles which surrounded it.

Medicines

- All wards had appropriate storage facilities for medicines, and safe systems for the handling and disposal of medicines.
- Most ward staff reported a good service from the pharmacy team, AMU short stay unit reported excellent pharmacy support, both departments worked to identify patients due for discharge and prepare their prescriptions promptly, streamline the process in obtaining medication for discharged patients, supported with a new pharmacy protocol tailored to AMU short stay unit. However ward 19 staff frequently experienced delays with obtaining medication for discharged patients which often arrived after 5pm, despite patients being discharged just after lunch.
- The trust had a pharmacist as controlled drugs (CD) accountable officer. There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient. Regular check of controlled drugs balances were recorded.
- All medicines were appropriately stored including patient medications in specific patient locked drawers.
- Nurses and doctors had achieved 100% in medicine management training.
- Fridge temperatures were regularly checked, recorded and adjusted as appropriate. However, we found no evidence that temperatures within medication storage rooms were checked.
- Medications on most wards were in date indicating there were good stock management systems in place, however we saw ward 18 had not recorded 'date opened' on a bottle of Oramorph and instead 'date opened' had been recorded on the box. The nurse escalated this to the ward sister.

Records

- Patient records included a range of risk assessments to include: Manual Handling, Falls, Nutrition and Pressure Ulcer damage with associated care plans. Risk assessments were completed and reviewed weekly in most wards except at ward 18. Risk assessments for three patients had not been updated for 2-3 weeks for nutrition and manual handling and daily skin inspection checks had not been carried out for all patients.

Medical care (including older people's care)

- The ward sister told us ward 18 was a flex capacity ward, which meant it was used to increase and reduce bed capacity depending on pressures for admission. The ward was experiencing staffing level issues and relied upon agency staff who did not always complete nursing documentation.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) paperwork was completed accurately and appropriately where indicated. There was evidence that decisions had been discussed with patients and their relatives.
- We saw comprehensive and well documented wound management plans. These showed wounds were assessed; treatment records were in place evaluated to show progress of healing.
- In most areas records were not stored securely; there were instances where patient records were stored in unlocked trolleys at unmanned nurse's stations. This increased the potential for patient confidentiality to be breached.

Safeguarding

- Staff were aware of the trust safeguarding policy and the processes involved when raising an alert.
- Staff received training at induction and at three yearly intervals, medical staff achieved 98% attendance against the trust's 85% target for Safeguarding adults (basic awareness) level 1, and met the target of 85% for safeguarding (enhanced awareness) level 2.
- Staff knew the name of the trust safeguarding lead, were well supported and told us they would seek advice if they had safeguarding concerns.
- We saw safeguarding alerts were completed within the recommended 24 hour timeframe and alerts were relayed verbally during staff handover times to ensure all staff were aware of patient's safeguarding issues.

Mandatory training

- Ward sisters from all wards told us staff attendance to mandatory training was an area for improvement. The trust's target for mandatory training attendance was 85% by March 2015. Across the medical directorate this was achieved in areas of falls awareness, manual handling theory and health and safety. However, attendance to fire safety was 60% year to date and manual handling for patients was 73%year to date. Specialist training for administering blood transfusions was 50%; attendance to basic life support was 63%. Attendance for emergency medicine staff and advanced nurse practitioners for advanced life support training was 30% year to date.
- Nurses and healthcare assistants told us they knew there were some gaps with their mandatory training, however the priority was ensuring safe staffing levels and training came secondary.

Assessing and responding to patient risk

- An early warning score system was used throughout the trust to alert staff if a patient's condition was deteriorating.
- We saw that the early warning indicators were regularly checked and assessed. Where the scores indicated that medical reviews were required staff had escalated their concerns. Medical reviews and repeated checks of the early warning scores were documented.
- Patient wristbands had a colour coded system to alert staff if the patient had known allergies or there was a risk of the spread of infection.
- Where patients required NG (nasogastric) tubes we saw that scans were used to ensure the tubes were correctly inserted into the stomach, reducing the risk of aspiration.
- Patients who were at risk of pulling out their NG tubes were identified and supported with padded mittens to reduce the risk of self-injury.
- All patients who were at risk of pressure damage were supported with appropriate pressure relieving equipment such as airwave mattresses and cushions.
- Doctors and Nurses reported continual pressure from trust to discharge patients as quickly as possible to free up beds required by newly admitted patients. Both nurses and doctors stated patients had been discharged too early which had resulted in poor discharge management, complaints by families and in some cases, readmissions to hospital.
- One patient on ward 17 was assessed as able to self-administer insulin. However, they were confused about their insulin dosage and had experienced frequent hypoglycaemic episodes (low blood sugars which can lead to a medical emergency) due a lack of food. We saw the patient's insulin had been changed three times in three days.
- Staff told us the patient had not been seen by the diabetic nurse specialist as there was no service

available at Solihull Hospital, it was only available at Heartlands and Good hope. However the trust had diabetic district nurse support for in patients, staff needed to request this additional support for patients.
- We were told the patient would be reviewed by the medical team and supported with their insulin administration by nursing staff.
- We saw a patient on AMU short stay ward who had 'diabetic' written above their bed. The patient was not diabetic but required reduced sugar intake due to a course of steroid therapy. The decision to label the patient as diabetic was taken by non-nursing staff. The ward sister was informed immediately.
- The AMU ground floor service had limited blood analysis service at night. Samples were sent to Heartlands Hospital and staff told us there was often a three hour delay before results were available.

Nursing staffing

- Ward managers and senior sisters met three times per day, 8am, 11am and 3pm to discuss bed capacity and nursing staffing levels to ensure beds were occupied and staffing levels and skills were appropriately deployed and shared across all wards.
- Ward sisters told us staffing levels was a daily concern and a high usage of agency staff was common practice, particularly for wards 17 and 18 where agency staff amounted to 50% of the workforce on the day of the inspection.
- Wards used the AUKUH acuity and dependency tool, designed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and patient flow.
- We were told by ward sister's data was collected and analysed annually to predict staffing level needs, however ward sisters were told they could escalate to matrons at any time if they had concerns about staffing levels or a patient needed one to one support.
- We saw there were gaps in the rota for some wards which were unsuccessful in filling vacant shifts.
- Staff told us they regularly worked over their contracted hours due to staff shortages and on the day of the inspection we saw a member of staff from ward 19 had come in on their day off, saw their colleagues were struggling to deliver care and helped out unpaid.
- One ward sister told us "Staffing levels are not unsafe, but they are not ideal either, we cannot rely on the skill mix as you never know what the bank or agency nurse can do until they arrive on the ward".
- Nursing staff had been moved from their regular ward to other wards to due to staff shortages. Staff did not feel that they had the skills or experience to adequately care for patients on theses wards; we saw this was a similar picture across all three hospital sites.

Medical staffing

- Doctors from all levels from junior doctors to Consultants level reported being under pressure.
- Ward rounds by consultants were daily on weekdays and at weekends only for newly admitted patients.
- Ward rounds in most areas were conducted by doctors only because there were insufficient nurses available. However, ward 19 conducted joint medic and nursing ward rounds which were seen as a model of care, improving inter team communication and improved care for patients. Doctors reported joint ward rounds saved time and reduced duplication.
- Locums were used to backfill medic vacancies, sickness and annual leave.
- AMU ground floor provided consultant cover from 07.30 to 9pm. Night cover was provided by the on call consultant and weekend cover was provided by on-call consultant working 8pm Friday until 9am Monday for new patients only.

Are medical care services responsive?

Requires improvement

Summary

Whilst staff responded to patients needs across medical wards there was continual pressure to free up ward beds for newly admitted patients. This meant that some patients could not be placed in the right bed at the right time for their needs. Discharges were sometimes rushed which resulted in complaints from families or readmission to hospital.

Service planning and delivery to meet the needs of local people

- As a result of high admissions medical patients were admitted to non-medical wards; 17, 18 and 19. This is referred to as medical outliers. However following the

inspection the trust made us aware that wards 17 and 19 did routinely admit general medical patients despite they being speciality wards. During our inspection there were approximately 39 patients occupying beds in wards which did not provide the primary specialism to meet their needs. For example ward 18 was a flex ward, previously offering medical care. The ward had recently reopened and had admitted two patients with significant mental health needs requiring continual supervision and one patient with oncology needs.

- Some doctors expressed concerns that this was a risk which could mean that patients did not receive the care and treatment they required because they were not in the "right bed".
- Nurses told us, there is a risk that medical patients may get missed from the ward round especially if a locum doctor is on duty who is not familiar with all the patients, occupying beds in other wards.
- Solihull hospital had recently closed its dementia ward. Patients living with dementia occupied beds in other wards. An in-reach team was available to offer support.
- The team were reliant on referrals into the service; there was no current structure in place to identify patients on admission which meant there was often delays from admission to referrals.
- We were told by staff the trust had a diabetic specialist team who provided care and support to staff and patients at Heartlands and Good Hope Hospital; however this team did not visit patients at Solihull. This meant patients with complex diabetic needs did not receive the same access to this specialist service as patients at other sites.

Access and flow

- Several wards were described by nursing staff as being in a transitional stage and appeared disorganised and complex in terms of admission criteria and discharges. For example, the AMU short stay ward originally intended as the first point of entry for patients referred to hospital as emergencies by their GP. It was also for patients requiring admission from the Emergency Department. Patients were assessed, stabilized and either discharged to another ward or discharged home.
- Staff believed that up to half of beds were occupied by patients with gastroenterology needs, three of whom has been there for several weeks and one who had been there for more than one month. Following the inspection the trust confirmed the unit was a mix of short stay; general medicine patients (significant numbers of frail elderly); and some gastro.
- We were told the AMU ward was trialling a new discharge system, the aim was to identify patients, initiate care packages quickly and discharge patients home. However, nurses were confused about the new system and told us it was very complex and described the process as "exceptionally challenging".
- Patient discharges rarely occurred before mid-afternoon. The trust had introduced the "JONAH" discharge planning database across all wards which provided a multidisciplinary approach to patient discharge. In addition to this process senior management had piloted a new discharge system at AMU short stay, to work in line with "Jonah" to speed up the discharge process for patients identified as medically fit. The pilot involved streamlining the discharge process by removing the need for a social service assessment which was recognised as one of the main delays in the discharge planning process. This was in agreement with Solihull Social Service. Nursing staff were unable to describe the process in detail as they found it confusing and complex. The concern pilot had been quickly introduced by senior managers without ensuring nurses fully understood the process.
- Ward 18 previously provided care for patients with medical needs. Staff told us it was closed and reopened as a flex ward. This meant instead of the ward providing care for one speciality, ward 18 admitted patients with a range of conditions. This included complex mental health problems, patients with oncology needs and respiratory needs. Staff told us they were not supported by the trust to care for such a diverse range of conditions and coupled with staff shortages they were not providing the quality of care the patients deserved.
- We looked at the admission criteria for patients being admitted to ward 18. We saw out of 12 criteria points laid out by the trust seven points had been breached and patients had been admitted who did not satisfy the trusts' own criteria.
- Staff told us they were just about "getting through each day" and had no say on who was being admitted.
- We saw several patients who were medically fit for discharge across AMU short stay, wards 17, 18 and 19, however, due to delays with social care packages or long term placements there were no plans for discharge.

Medical care (including older people's care)

Meeting people's individual needs

- Risk assessments were completed and care plans in place for patients in most wards.
- Single-sex bays were in place across all medical wards.
- An in-reach dementia team had been set up at Solihull hospital consisting of one nursing sister, three nurses, five healthcare assistants and eight volunteers. The team identified patients in all wards and provided practical support to staff and relatives to help care for patients. They also provided a link to relatives when the patient was discharged home.
- Specialist nurses for tissue viability and heart failure provided individualized care for patients with these specific conditions.
- Support was provided by the speech and language therapists for patients with aphasia following a stroke.
- Interpretation services were available in both the form of a language line (a telephone translation service) and face-to-face interpreters.
- The chaplaincy team offered religious and spiritual support to patients and relatives.
- Staff were heard shouting out across the area to a colleague about moving the Christmas tree; this woke a patient up who said. " It's so noisy here, staff are always shouting over each other, there's no privacy or thought for ill patients"

Learning from complaints and concerns

- Patients across all medical wards were satisfied with the quality of service they received. We were told by several patients nurses were kind and caring but often rushed around the ward.
- Staff followed the trusts complaints policy and provided examples of when they would resolve concerns locally and how to escalate when required.
- PALS (Patient Advice and Liaison Service) leaflets were not readily available for patients as they were often displayed by the nursing stations and not by the patient's bedside.

Are medical care services well-led?

Requires improvement

Summary

Staff across all medical wards were dedicated and compassionate, despite the majority of staff feeling despondent. Local leadership was supportive and nurturing. Ward sisters and ward managers demonstrated they cared for their staff as much as their patients. However, staff could not articulate the trust vision and felt decisions were made without their engagement. Staff felt ignored by middle management and the trust executive team unless there was a problem and then a 'heavy handed approach was adopted.

Vision and strategy for this service

- We talked to 27 staff from various disciplines and grades and no one could articulate what the trusts or their respective service's vision or future strategy was.
- Individual staff spoke with pride and compassion about what they thought good care looked like and how they demonstrated this on a daily basis.
- One ward sister told us " I'm sure there is a trust vision, but we don't have time to stop and look for it and no one has ever told us what it is"

Governance, risk management and quality measurement

- Governance initiatives were carried out monthly to measure risk and quality on medical wards. These included patient safety thermometer audit conducted on each ward monthly and a monthly audit of areas of potential risk to include: falls, pressure ulcer prevention, cannula checks, and commode cleanliness.
- Ward results were displayed on corridors and any wards who fell into the red area were given an action plan to follow to improve future practice.

Leadership of service

- All nursing staff spoke highly of senior sisters and ward managers as leaders and told us they received good support.
- We observed good working relationships between nursing, therapists, specialist nurses and medical staff across all medical wards.
- Annual staff appraisals had not been conducted for all staff. Nurses told us appraisals are rushed and they are linked to the pay incremental process. This meant if staff do not receive an annual appraisal, there is a risk they will not receive their pay rise.
- We saw one nurse had not received an appraisal since 2011.
- Concerns relating the AMU ground floor service were added to the trust's risk register, however staff told us management do very little to respond to these issues.

Medical care (including older people's care)

Culture within the service

- We found in general staff were hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed how dedicated they were in what they did, despite the majority of staff feeling despondent.
- Senior sisters and ward mangers told us they felt decisions relating to the management of their wards and staffing were often taken without their involvement and usually with very little notice.
- Staff were aware of some members of the executive team but felt they were not approachable and described the overall trust management style as; forceful and aggressive.

Public and staff engagement

- There was an inconsistency across services about giving patients information and details about how to raise concerns or complaints. Some wards displayed information in communal areas which was not easily accessible for patients who rarely mobilised outside their bays.
- Wards were closed and reopened without prior communication with ward staff.
- Communication from middle management required improvement as nurses told us they had little opportunity to voice their opinions or concerns and one senior sister told us, " We do what we are told ".
- Staff felt a 'heavy handed approach' was taken to problem solving by the executive team.

Innovation, improvement and sustainability

- The opportunity for clinical excellence to flourish across medical wards depended on individual team's workload. Many staff we talked to reported their focus was purely on delivering patient care.
- Areas of good practice related to the AMU short stay senior sister who had been recognised as a 'leading light' for Compassion in Care.
- 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.

Surgery

Safe	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Not sufficient evidence to rate
Overall	Not sufficient evidence to rate

Information about the service

Solihull hospital provides day and inpatient surgery for specialisms including cardiothoracic, orthopaedics and breast and vascular surgery.

We inspected theatres, the day procedures unit and three wards. We spoke with 13 staff and 10 patients. We observed care and reviewed records as part of this inspection.

Summary of findings

Staff rarely received feedback on lessons learnt following reported incidents. Equipment was not stored appropriately causing trip hazards and faulty machinery was not repaired in a timely manner. The World Health Organisation (WHO) checklist was not always done in the anaesthetic room. Data was input to an IPAD later, which could lead to potential errors of recording.

There were delays in theatre due to staff shortages on the wards resulting in delays of up to an hour per day. Theatre staff said there was an issue with not having interpreters available, resulting in many operations being delayed or cancelled.

Staff on one of the surgical wards told us they had never seen the executive team but knew the senior site team. Theatre staff said they, “Felt left out of the loop, isolated and unwanted.”

Surgery

Are surgery services safe?

Not sufficient evidence to rate

Staff were aware how to raise incidents but rarely received feedback on lessons learnt following incidents that had been reported. Documents submitted by the trust regarding never events demonstrated that there have been two for surgery in 2013/14. One being a retained swab and the other wrong site surgery trust wide. Three others had occurred in the previous year. These figures relate to trust wide. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The safety thermometer was in use in the surgical directorate but not within theatres. This was not always displayed at the entrance to the surgical wards for staff and the public to see. We saw that the data indicated good compliance with VTE assessments, prevention of UTI's in catheterised patients and pressure area care and assessment. Data supplied by the trust demonstrated for the month of October 2014; wards 14 and 15 for harm free care was 100% and 95% respectively. Notably ward 14 had improved from the previous month when there was a twelve month low of 88%.

The hospital did not achieve compliance with 'Infection Control (Hand Hygiene and Sharps and Inoculation incidents)' achieving a score of 79% which was red rated. This is hospital wide not surgery specific.

The ophthalmology day surgery unit was not suitable for wheelchair users. Equipment was not always stored appropriately causing obstructions and trip hazards. An assessment conducted by the trust's manual handling advisor of the ophthalmology day surgery facility concluded that it was not suitable for people using wheel chairs. Both ward and anaesthetic areas were too small to enable staff to deliver essential care. Cables were trailed all over the recovery room floor causing a potential trip hazard.

One of the anaesthetic machines was not functioning and there was no back up machine. This had been reported in August but no action taken.

There was a large pile of condemned equipment on the way to the endoscopy theatre which was partially blocking the corridor. Staff had been phoning daily since 19th November to have this removed but with no response.

Each anaesthetic room did have a lockable fridge but these were not locked at the end of each session, only at the end of each day.

Staff told us and we observed that the World Health Organisation (WHO) five step to safer surgery checklist was not always done in the anaesthetic room. An IPAD was used but staff reported connection problems and data was input later. This could lead to errors for example a drug dose not being properly recorded.

Surgical staff had undertaken safeguarding adults training level 2 achieving 88% completion rate. Documents supplied by the trust demonstrated 100% compliance with manual handling training.

The management of deteriorating patients was monitored to ensure if a patient had a score of six or above that senior clinical review was undertaken. We saw on ward dashboards that the surgical wards had achieved 100% for this measure for October 2014 when applicable with the exception of one month on ward 15.

We saw measures for the "proportion of shifts reported as having a nursing shortfall" for October 2014 was 25% average on the surgical wards.

Are surgery services responsive?

Not sufficient evidence to rate

There were delays in theatre due to staff shortages on the wards resulting in delays of up to an hour per day.

Theatre staff told us there were delays due to staff shortages on the wards. This resulted in delays of up to an hour per day. We noted that in documents supplied by the trust that patients experiencing delays of 30 minutes or more in recovery was rising.

The trust recorded the number of cancelled procedures in theatres trust wide. Within day surgery we saw comparisons between 2013/14 and the current year 2014/

Surgery

14. April to October (seven months) the trust recorded cancellations higher than the previous year on four occasions. Time to theatre was not recorded for Solihull site in the trust quality account.

Staff in theatre said there was a major issue with not having interpreters available resulting in operations delayed or cancelled.

Are surgery services well-led?

Not sufficient evidence to rate

Staff on one of the surgical wards told us they had never seen the executive team but knew the senior site team. Theatre staff said they, “Felt left out of the loop, isolated and unwanted.”

Friends and family tests responses were sought and received for surgery. The response rates for October 2014 were ward 14 67% and ward 15 3%. The ward 14 achieved the trust target and ward 15 did not for the same month.

Maternity and gynaecology

Safe	Requires improvement
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The Netherbrook birth unit at Solihull hospital managed 352 (2012/13) births, providing care for low risk women who choose midwife led care. There is also a small antenatal clinic providing outpatient care for both high and low risk women.

During our inspection we spoke to 6 staff, and 2 patients in the antenatal clinic, there were no patients being cared for in the birth unit during our visit. We visited the birth centre and antenatal clinic.

Summary of findings

The Netherbrook birth unit was appropriately staffed with a good skill mix. The checking of emergency equipment needed to be improved and arrangements for evacuating women from the birth pool.

The unit would have benefitted from more staff involvement in future service provision. However, the service was flexible in catering to women's needs and accommodated partners.

Good local leadership was displayed and was staffed by a motivated team who supported and welcomed midwives who rotated into the unit.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Summary

The Netherbrook Birth Unit staff rota's demonstrated a robust system for maintaining an appropriate skill mix, and staff felt well supported by their colleagues.

There was some out of date equipment found in both the antenatal clinic and the birth unit, and systems for checking emergency equipment were not being followed.

There was a concern about the pool evacuation policy and there was no documentation to evidence that all staff were trained to use the hoist.

Incidents

- No Never events have been reported since 2012.
- Most staff said they were aware of how to report an incident and that they would receive feedback individually if they included their contact details on the report. They understood that wider learning would be disseminated in the staff communications such as 'Matty Chat' and the Governance Team Newsletter.

Safety thermometer

- There were no dashboards displayed for staff or visitors displaying key safety or infection control indicators. Staff were informed about performance against key performance indicators by a Trust wide communication 'Midwifery Metrics News' which detailed site and individual ward performance but was not linked to Trust wide or National targets which would be useful for comparison.
- In September 2014 the midwives at the Netherbrook birth unit delivered 22 babies. 13 of which (29.1%) were born in water.

Cleanliness, infection control and hygiene

- Pool cleaning schedules were available and showed that the birth pools had been cleaned daily with three exceptions over the last month.
- Infection control standards and results are published monthly as one figure across the across the three hospitals.
- Compliance for hand hygiene, bed space and cleaning, uniforms, and alcohol gel and merged with privacy and dignity indicators and aggregated to a final percentage. This is circulated to staff via the Midwifery Metrix news although the displaying of individual ward compliance was not observed.
- 'I am clean' stickers were observed on equipment which were ready for use.

Environment and equipment

- There were no records available demonstrating staff competency specifically to use the hoist over the birth pool, and staff said they 'trained each other' to use it. The water birth flow chart is not specific about whether to use the net or hoist in an emergency stating 'use available evacuation equipment' which could lead to confusion and compromise safety.
- Out of date syringes and swabs were found in both the antenatal clinic and the birth unit.

Medicines

- The emergency pre-eclampsia box in the antenatal clinic which was meant to be checked weekly had only been checked twice in 2014, and contained out of date blood bottles.

Records

- A new 'Badger' electronic record keeping system had recently been introduced which was being used alongside paper records. Staff confirmed that although they saw this as an improvement in the long term, the transition phase meant there was duplication in record keeping causing delays in patient care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

- All staff receive safeguarding training every three years which includes mental capacity act training

Safeguarding

- There were adult safeguarding procedures in place supported by mandatory staff training, in September 2014 the training records demonstrated the trust had met its target of 85 % compliance for Safeguarding Adults and Children's Training level 1 and 2.
- We found that there were safeguarding policies in place with clear procedures for staff to follow should they have a concern
- There was a safeguarding team of four specialist midwives who dealt with adult and child safeguarding concerns and provided training across the three sites.

Maternity and gynaecology

Mandatory training

- The Trust had produced a booklet 'Mandatory Matters' which documented mandatory training requirements and how to access this for every staff group.
- The process for monitoring compliance of mandatory training is set out in the Training Needs Analysis for the Obstetric Department and appears robust, staff advised us they were able to book and attend mandatory training.
- Training did not appear as a standing item on the weekly Band 7 meeting or the Head of Midwifery and Senior Managers Meetings.
- Overall Trust compliance for mandatory training in the Women's and Children's Division, September 2014 stood at 74% year to date, against a target of 85% by March 2015.

Assessing and responding to patient risk

- The Obstetric Modified Early Warning System (Obstetric MEWS) training was delivered to all staff as part of the Obstetric Emergency Day (Skills Drills).

Midwifery staffing

- The birth unit was led by a band 7 midwife, supported band 6 core midwives, community midwives and maternity support workers. This was a new staffing model that had been implemented shortly before our visit.
- The staff rota's demonstrated a robust system for maintaining an appropriate skill mix, and staff felt well supported by their colleagues.

Are maternity and gynaecology services responsive?

Good

Summary

Although there was an active Maternity Services Liaison Committee, there was little evidence of staff or patient involvement in service planning and delivery to meet the needs of local people.

The birth unit was flexible to accommodate women's choices for either early discharge or overnight stay, and partners were encouraged to stay overnight if that was their choice.

Service planning and delivery to meet the needs of local people

- We saw minutes of the Maternity Services Liaison Committee which met Bi-monthly. Clinicians and managers from all three sites attended, along with representatives from SANDS (Stillbirth and Neonatal Death Society), and other local community groups representing women and children.
- Staff could not tell us how service users were engaged to influence the design and delivery of services.

Access and flow

- Women booked to give birth at the birth unit after they were risk assessed after 36 weeks. They had the option to leave four hours after delivery or to stay overnight – there were rarely capacity issues which necessitated early discharge.

Meeting people's individual needs

- Women with disability or learning difficulties rarely used the birth centre therefore there were no specific facilities to support them, although staff said they would risk assess women and accommodate them if they were otherwise suitable for a midwife lead birth.
- Language line was available, although was rarely used as staff in the birth unit said they used relatives to translate.
- Partners were encouraged to stay overnight on the birth unit if they chose to do so.

Learning from complaints and concerns

- Staff described the complaints procedure and understood the escalation process if a complaint could not be resolved immediately. However they all said that complaints in that environment were very rare.

Are maternity and gynaecology services well-led?

Requires improvement

Summary

Staff told us of good and supportive local leadership; although they did not feel senior managers were visible.

Good team work was observed in the birth unit with effective risk assessments of women and self-assessments of staff in order to maintain their competencies.

Maternity and gynaecology

Vision and strategy for this service

- The trust had set out its' vision in a Maternity Strategy document, which was available as a leaflet and on its website and in several different languages, although staff were not aware of the existence of a strategy or its key priorities.

Governance, risk management and quality measurement

- Every woman was risk assessed for suitability for midwife lead care on admission to the birth unit, and these risk assessments were reviewed by a member of the core team if they were completed by a community midwife.
- If a community midwife was new to the birth unit environment, or felt she needed to update her skills, she was encouraged to fill in a self-assessment questionnaire to identify her development needs and a bespoke support programme was devised for her.
- Staff appeared happy and confident in their roles and community and core midwives worked well together in a cohesive team. However since this staffing model had only been put in place recently, staffing at the birth unit appeared on the obstetrics risk register.

Leadership of service

- Staff felt that they birth centre was well –led up to matron level, and felt the Matron were visible and supportive. They did, however speak of a lack of senior leader visibility, and were not familiar with the senior leadership structure and unable to tell us the names of senior leaders within the Maternity directorate or to say when they last saw them.
- The Head of Midwifery stated that it was impossible for her to be visible across the three sites, however had invited all Band 7's to attend a meeting to support their development and increase her visibility.
- There appeared to be a lack of leadership in the antenatal clinic, with no-one taking ownership when the issue of out of date equipment or the pre-eclampsia box was highlighted to them.
- The most recent Local Supervisory Report stated that the Supervisor of Midwife to Midwife ratio for the overall trust was 1:18 (worse), against a recommended 1:15, however they were reassured that the trust was actively recruiting Midwives to become Supervisors of Midwives to address the deficit. There was a Supervisor of Midwives rota that provided 24 hour a day, 7 day a week on-call cover across all the sites.

Public and staff engagement

- Staff in the birth unit were aware that their service needed to be promoted in the community, and discussed staffing the birth unit partially with community midwives as an opportunity to encourage suitable women to use the service.
- The Matron responsible for the birth unit and the antenatal clinic had a reputation of being approachable and open to listening to staff's ideas for service improvement.

Innovation, improvement and sustainability

- The Netherbrook birth unit fits into the trust strategy which sets out to focus on normal birth and improved choice and outcomes for women and their families as key priorities for 2014/2015.
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Outpatients and diagnostic imaging

Safe	Good
Responsive	Good
Well-led	Requires improvement
Overall	Good

Information about the service

The outpatient department is located at the entrance of Solihull Hospital. Diagnostic departments are close to the outpatient department. Paediatric outpatients are well signposted and were not inspected at this time. We visited the main outpatients departments and saw approximately four clinics running. We reviewed the practices of the main outpatients department and went to the central booking service for outpatients at Linden Place.

We spoke with four members of outpatient's staff, the bookings manager and five patients.

Summary of findings

The outpatient department at Solihull Hospital were safe, and responsive to patient's needs. Whilst there was a lack of performance data to enhance services local staff had taken the initiative and addressed the issues raised by patients at the hospital. An example of this was the introduction of an efficient system for seeing patients who arrived on stretchers via ambulance. The hospital utilised the services of a large body of volunteers to assist the department and to ensure that patients were seen in an efficient manner.

Patients we spoke with were very satisfied with the service provided and stated that care and medical staff had time to talk them through their care and treatment. There was plenty of information available to patients both in written form and verbally on their care and treatment. The environment was pleasant and patients did not experience delays in treatment.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

Summary

Staff reported incidents where these were recognised. Feedback on incidents reported was not consistent but occurred through huddles taken to disseminate information. The environment was visibly clean and patients were observed and offered care as necessary. Equipment and medication was stored and maintained appropriately and there were sufficient staff on duty to ensure safe care.

Incidents

- Staff in the outpatients department felt that the department was safe. We saw that the department had reported 74 incidents within the previous year. The largest number of incidents was recorded as records and documentation but due to limited understanding of the categories it was unclear as to what these related to more specifically.
- Most staff were aware of how to report incidents or to raise concerns. However, they stated that they would not report late running of clinics or cancelled clinics as an incident this meant that opportunities for trending and learning and hence improvement were lost. Staff believed that this was recorded by the central booking team.
- We could not follow an incident to ensure that investigation and learning had taken place as staff could not describe the last incident that occurred. Neither could staff discuss any action taken as a result of an incident within the hospital or trust. Some staff felt that feedback from incidents was not received. However we were informed that huddles occurred where staff discussed issues of note and agreed action to be taken.

Cleanliness, infection control and hygiene

- The environment was visibly clean. Staff told us that they cleaned the clinic rooms at the start of a clinic and cleaning records supported this.
- Staff were aware of infection control processes such as use of personal protective equipment and hand hygiene
- Staff observed hand hygiene and bare below elbows policies of the hospital.
- Hand gel dispensers were available and were fully stocked.

Environment and equipment

- Equipment was maintained and PAT tested in line with trust policy. Labels were seen on equipment which identified when this had been last checked. All equipment seen had been checked within the previous year.
- The resuscitation trolley in the outpatients department was checked to ensure that stock was in date and items were available.

Medicines

- Medicines were kept in locked cabinets and keys were maintained by outpatient personnel. Daily checks were undertaken and documented in respect of medicines and storage of medicines. Storage was locked and medicine expiry dates were checked by staff.

Records

- Medical records were available for clinics. The central booking system sent copies of clinic lists to the medical records department to ensure that patient's records were sourced prior to the clinic occurring. However there was no check on the numbers of records not available for clinics undertaken to ensure efficiency of this system.
- Medical staff recorded in patient's records and care staff recorded basic monitoring of patients weights and diagnostic tests as appropriate.
- Nurse led clinics were undertaken where nursing staff recorded detailed notes of patients care whilst in the department.
- Risk assessments were undertaken within the department, although staff were not aware of any issues on the risk register.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of caring for people who may have limited capacity but were unaware of the deprivation of liberty safeguards.
- Staff undertaking procedures were aware of consent implications and completed the appropriate documentation as necessary.
- Implied consent was taken for examinations and basic testing of patient's metrics. Staff explained procedures and patients willingly submitted to having these undertaken.

Outpatients and diagnostic imaging

Safeguarding
- Safeguarding training had been undertaken and information was available. Staff had not referred anyone to the safeguarding team internally for some time.

Mandatory training
- Staff undertook mandatory training. This was done through eLearning and through face to face training. Records showed that the department had achieved the 85% target set for this training.
- Staff were able to access time for training through use of quieter clinic times.

Nursing staffing
- The department was fully staffed and staff felt that there were enough staff on duty at any one time.
- Trained nurses were used to undertake complex clinics and undertook nurse led clinics.
- Some clinics were facilitated by healthcare assistants. Healthcare assistants felt that they could approach a nurse if they needed extra support or advice.

Medical staffing
- Medical staffing was provided by the specialty holding the outpatient clinic. A variety of medical and allied healthcare professionals were available within the outpatient department.
- In general clinics were held by senior medical professionals.

Major incident awareness and training
- Staff were unaware of a major incident plan and had had no training as to what to do in the event of a major incident occurring.

Are outpatient and diagnostic imaging services responsive?

Good

Summary
The outpatient department is responsive to the needs with services planned to meet the need of the local population. However for patients on an individual level using this service further improvements could be driven through effective use of data on the performance of the clinic. Generally clinics were not available out of working hours apart from a few new clinics initiated recently.

The needs of different people were taken into account such as the vulnerable, we saw a large body of volunteers who supported people using the department.

Reasonable adjustments were made for people with mobility issues and they were also supported by both porter staff and volunteers.

Booking systems are ineffective with patients being sent to the next clinic rather than clinics held in their local hospital. There were disparate systems for different types of referral which mean that some patients referred by written letter wait longer for appointments than those who are referred either electronically or through Chose and Book systems. It was unclear as to how many clinics are cancelled at either short notice or within the allotted six weeks as no audits are undertaken. Similarly audits were not undertaken of delays and over running clinics. This meant that improvements in responsiveness could not be planned or implemented.

Service planning and delivery to meet the needs of local people
- Clinics were generally held Monday to Friday within working hours. Staff were aware that some clinics had been scheduled for weekends but this was in response to waiting lists rather than for the benefit of patients.
- There were no booked evening clinics.

Access and flow
- The hospital was not meeting 18 week referral to treatment times and was undertaking some initiative clinics to address this issue.
- Bookings are collated centrally for all outpatient departments. The trust ran two systems for waiting lists one of which ran the risk of breaching the 18 week RTT. There was no evidence of monitoring the length of time it takes to book patients from GP referral letter.
- Within the outpatients department clinics were signposted by number and patients reported to the appropriate reception desk on arrival. There were individual waiting areas for clinics although patients sometimes sat in adjacent waiting areas when clinics were busy.
- Within the outpatients department there was a main desk where patients reported to on arrival prior to arrival at the allocated clinic. A large body of volunteers assisted patients to the correct clinic at which staff greeted them positively.

Outpatients and diagnostic imaging

- Staff could tell us which clinics always ran late and which were often delayed. There was signage for patients to inform them of delays over 20 minutes in clinics. Patients felt well informed of delays and were satisfied with the service.

Meeting people's individual needs

- Staff were aware of dealing with patients who may be vulnerable. Staff were situated in the clinic waiting area and were able to meet patient's individual needs.
- Patients with learning disabilities were similarly treated. However there is no flagging system for any patient with special needs.
- There was an awareness of dementia but no special training had been given. Care was dependent on the person organising the clinic.
- Wheel chairs were available within the hospital for those patients who required them and porters and volunteers were on hand to assist patients attending alone.
- There were a number of specialist staff available in clinic to provide information to patients; diabetes nurses were available as were urology and gynaecology nurse specialists.
- There were a number of leaflets available within the clinic environment for most conditions. Leaflet racks were well stocked and used by patients.

Learning from complaints and concerns

- Staff maintained a communications book where informal complaints from patients were recorded. Staff could not remember the last time someone made a formal complaint. The communication book was informally monitored by local senior staff.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Summary

The arrangements for governance and performance management did not always operate effectively. Opportunities for improvement in the service, identified through audit and monitoring of the service, needed to be initiated and embedded. Staff were well supervised, supported by local leaders but senior managers were less visible at this hospital. Staff felt passionate about giving a good service and they took action to address issues which were within their control.

Vision and strategy for this service

- There was no recognition of a strategy, vision or values within the department. Staff were unable to articulate a vision or plan for the department.
- Staff were clear about their role in contributing to the overall goal of the department and were determined to provide a good service to patients.

Governance, risk management and quality measurement

- There was a lack of governance systems to ensure the department improves.
- We saw evidence of audits undertaken locally in respect of medicines and infection control. However there was limited information on performance of the service in respect of cancelled clinics and delays for patients. This meant that these issues could not lead to improvements in the service.
- Staff were unaware of risk registers and risks to the service.

Leadership of service

- The outpatient manager worked predominantly in Heartlands Hospital but visited regularly Solihull Hospital. All staff felt supported by the visiting manager and by other senior members of the team.
- Staff told us that the trust management were not visible and they did not know who was above their immediate line manager.
- Appraisals were undertaken annually but there was no other form of formal supervision.

Culture within the service

- Staff within the department felt that managers supported the team within the department.
- Staff felt that the managers had an open door policy and that they were approachable but action taken to address issues was limited.
- Staff reported that the department was a close knit community of people who had worked there for some time and took a genuine interest in each other.

Public and staff engagement

- Staff felt ownership of the department and felt that they could and had taken action to address local issues.

Outpatients and diagnostic imaging

However they did not feel empowered to raise any issues which could not be addressed within the local team to a senior level. Nor did they feel engaged in the wider trust issues.

- Staff and leaders told us that team meetings did occur but were not formally minuted.

Innovation, improvement and sustainability

- Staff were keen to improve services and had taken action y on a local level to address patient concerns. This included the implementation of a pathway for patients arriving on a stretcher.

Outstanding practice and areas for improvement

Outstanding practice

Medicine

- Areas of good practice related to the AMU short stay senior sister who had been recognised as a 'leading light' for Compassion in Care.
- 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.

Areas for improvement

Action the hospital MUST take to improve

Medicine

- The trust must ensure all fire doors and exits are free from clutter.

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.

Action the hospital SHOULD take to improve

ED

- The trust should ensure that locum doctors in the ED have the expertise that they need at hand at all times including overnight, to manage any patient condition that may present.
- The trust should ensure that site escalation procedures support the Solihull Hospital ED more effectively.
- The trust should ensure that steps are taken to more effectively address the confusion over what services Solihull Hospital ED offers and the role of the MAU in relation to the ED.
- The trust should ensure that identified risks and shortfalls in compliance relating to Solihull Hospital ED are specifically addressed in action plans for improvements.

Medicine

- The trust should ensure all fire doors and exits are free from clutter.
- The trust should ensure patient risk assessments are completed and regularly reviewed for all patients.
- The trust should ensure reducing the noise level and improve communicating (verbal) confidential information at the AMU ground floor service.
- The trust should consider using assessment rooms fit for purpose at the AMU ground floor service and not admin offices or bereavement rooms.
- The trust should ensure al staff receive an annual appraisal.
- The trust should improve on mandatory training attendance and also specialist training such as: administering blood transfusions and advanced life support training.
- The trust should continue with its Registered Nursing recruitment process and reduce the use of agency staff as a priority.
- The trust should ensure staff are given training how to report poor staffing levels via the electronic system.

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. Patients waiting over 30 minutes in recovery Service delivery and improvement in OPD with the use of management reporting data

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 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.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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 15 HSCA (RA) Regulations 2014 Premises and equipment 15 (1)(f) **Lack of equipment and faulty equipment not being replaced in a timely fashion.**
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.**