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

Accident and emergency	Requires improvement
Medical care	Requires improvement
Surgery	Good
Intensive/critical care	Requires improvement
Maternity and family planning	Good
Outpatients	Good

Summary of findings

Overall summary

The ratings in this report were awarded as part of a pilot scheme to test CQC's new approach to rating NHS hospitals and services.

Solihull Hospital is the smallest of the three hospital locations run by the Heart of England NHS Foundation Trust. It provides general and specialist hospital and community care for the people of East Birmingham, Solihull, Sutton Coldfield, Tamworth and South Staffordshire. Solihull Hospital has approximately 229 beds and provides elective surgery, general medical and minor injuries services on this site. Solihull Hospital also has the recognised stroke unit within the three hospitals, providing out-of-hours stroke treatment service. There are no children's services on site; unwell children who present themselves to A&E are assessed and transferred to Birmingham Heartlands Hospital.

We inspected the Heart of England NHS Foundation Trust as part of our new in-depth hospital inspection programme. This programme is being tested at 18 NHS trusts across England, chosen to represent the variation in hospital care across England. Before the inspection, our 'Intelligent Monitoring' system indicated that the Heart of England NHS Foundation Trust was a medium-risk trust. The trust had a longstanding history of struggling with turnaround times in the accident and emergency (A&E) department. The management team had put initiatives in place to reduce the amount of time people were waiting in A&E but these had not yet had an impact.

Before the inspection, we looked at the wide range of information we held about the trust and asked other organisations to share their knowledge and experience of it. We carried out announced visits to the Heart of England NHS Foundation Trust between 11 and 15 November 2013. We looked at patient records of personal care or treatment, observed how staff were providing care, and talked with patients, carers, family members and staff. We reviewed information that we had asked the trust to provide. Before visiting, we met with four local groups of people to gain their experiences of the trust, and during the inspection we held three listening events, one near each hospital location, so that we could seek the views and experiences of people using the service. We spoke to more than 60 people through these listening events.

The Heart of England NHS Foundation Trust, across all the three sites, is below the national average in the Friends and Family Tests introduced in both A&E and inpatients. This means that patients the numbers of patients who were likely to recommend the trust to a family member or friend was low. This was in contrast to the positive feedback from patients during the inspection, who felt that, overall, care was responsive and provided in a sensitive and dignified manner, despite caring staff being busy.

This hospital has been inspected four times. The first inspection took place in August 2011 and was found to be not meeting the standard on management of medicines. There were two inspections in 2012 – in the second of these we found the hospital was not meeting the standard on respecting and involving patients. The last inspection was in March 2013 and the hospital was meeting all the standards we inspected.

We visited Solihull Hospital on 15 November 2013. The inspection team visited the A&E, medical and surgical wards, the critical care unit and the midwife-led maternity unit. Additionally, focus groups were held with consultants, junior doctors, nurses, allied healthcare professionals such as physiotherapists and occupational therapists and non-clinical staff. We carried out an unannounced visit to the hospital on the evening of Saturday, 23 November 2013. During this visit we inspected the A&E, acute medical unit, critical care unit and some of the medical wards.

The current arrangements for A&E services at Solihull Hospital is in effect a minor injuries unit and a medical assessment unit jointly bearing an A&E sign. The provider and commissioners should work with the local community and other stakeholders so that it is clear to the public what services are provided at Solihull Hospital, from a safety perspective this is particularly true around children's services. In view of the above we do not feel it would be appropriate to rate this service as an A&E department.

Summary of findings

An acute medical unit (AMU) received ambulances and emergency medical patients and was run as a medical A&E unit. The local ambulance service was aware of this and thus diverted patients and children with non-medical conditions (that is, patients with suspected surgical complaints, children and trauma patients) to Birmingham Heartlands Hospital.

This department, while safe on the day we visited, had a lack of resources to be a medical A&E, was not staffed as an A&E (that is, it was run by medical doctors and nurses without specific A&E training) and did not undertake the monitoring that we would expect an A&E unit would. Unlike all A&E departments across the country, the acute medical unit is not 'on the clock'. This means that the staff are not accountable to see and treat their patients within four hours. Although the standard operating procedure states that any patients who are in the unit for longer than four hours should be moved to a separate area (called AMU 2), when we visited, this area had been closed because of a lack of available nursing staff. Many of the patients we saw in the unit had been there longer than four hours, and it was not clear how this was being monitored on a daily basis. Doctors we spoke to said it was not uncommon for patients to wait longer than four hours to be seen and, although we had no direct evidence that this was unsafe because they would have regular observations performed, this was not a responsive or patient-centred service. Ambulances were sent to the unit with patients with chest pain and could potentially arrive with a condition that required surgical treatment when no complex surgery was undertaken at the unit. This patient would then be transferred to another hospital.

We also found that critical care services provided at Solihull Hospital were below the level they needed to be. While no complex surgery was carried out at the hospital, this three-bedded area provided level 2 care for two cardiology patients with one bed identified as a high dependency bed (suitable for patients requiring more intensive monitoring or single organ support). Although the staff were skilled at looking after cardiology patients, they did not appear to have had sufficient high dependency training for the type of patients that could potentially be admitted to the unit. The unit also admitted surgical patients who had patient-controlled or epidural anaesthesia despite the fact that not all of the staff were necessarily trained to look after this type of anaesthetic.

Patients were seen on a daily basis (at weekend by a registrar only) but, on the day we visited, we found that notes were not always clearly transcribed and staff were unclear as to who had written them and what time they had been reviewed. We also noted on our unannounced inspection that only 11 of the 25 members of staff on the list to have their competency training package completed had signed to state that they had begun working on this. A responsibility of the nurses on the critical care unit was also to observe the electronic monitoring of up to six patients on an adjoining ward. However, this was not always possible when providing care for patients within the critical care unit. These patients were on an adjoining ward with a full complement of staff.

Staff working on the Solihull site told us they were only given one opportunity to rotate within the wider critical care directorate to ensure that their skills were updated and enhanced, but that this was only for one week and it was not clear if it was a regular event or a one-off.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Most of the services on the Solihull site were delivering care that was considered to be safe.The area of the medical assessment unit was found to be safe at the time of the visit in terms of patients attending and staffing available within the area but this could quickly become unsafe if a patient who did not fulfil the criteria walked in off the street. The critical care unit was also considered safe at the time of our inspection but the lack of training and experience of staff and the types of patients admitted could potentially become unsafe. We judged that the services provided at the A&E were that of a minor injuries unit and as such were safe however we were concerned about the number of children the department saw without having a paediatrician as part of the medical team and limited supply of resuscitation equipment available for children on site.

Are services effective?

Services demonstrated good evidence-based practice, with staff involved in developing protocols and guidelines. There were dementia champions in some areas.

Are services caring?

Patients reported positively that the services and staff were caring and focused on the needs of patients. The trust is below the national average in the Friends and Family Tests introduced in both A&E and inpatients.This means that patients the numbers of patients who were likely to recommend the trust to a family member or friend was low. This was in contrast to the positive feedback from patients during the inspection, who felt that, overall, care was responsive and provided in a sensitive and dignified manner, despite caring staff being busy.. Staff we spoke to offered patient-centred care.

Are services responsive to people's needs?

Services at Solihull Hospital were responsive to patients' needs. Focus groups were held and interpreters were available. The way services were configured had been adjusted based on the ability of the service to respond to people's needs. We saw posters showing how the hospital had responded to feedback from patients and in one instance had invested £150,000 in building five cubicles and a larger waiting room.

Are services well-led?

There were clear examples of some good leadership at this hospital. However, the senior management team was not always visible on site. We saw there were proactive teams with a strong culture. There was a concern that communication and the cascade of information may not be reaching all staff. The lack of clarity over the extent of some of the services indicated that they

may have fallen 'below the radar'. However we saw that active steps were being taken by the trusts leadership team to manage the issues we have highlighted at the trust and that they were already in progress prior to our visit. We saw a visible sense of diversity among the staff.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

Requires improvement

The signposted A&E service saw about 35,901 adult patients a year; and 8,758 children. There were good policies and good team working by the staff in the unit. As a minor injuries unit, it was safely resourced and run. However, it does not have the resources of an A&E unit. The unit has medical cover from 8am to 8pm, after which cover is provided by an on-call system.

The current arrangements for A&E services at Solihull Hospital is in effect a minor injuries unit and a bearing an A&E sign. The department does not accept patients by ambulance unless to the Medical Assessment Unit as It has no capability to treat major trauma. However, there was significant potential for major trauma patients to arrive other than by ambulance as patients walk in to the A&E department. These patients would then be stabilised and sent to a trauma centre. Staff reported that, at times, trolley patients overflowed from the acute medical unit into the A&E unit where they would be looked after by the nursing staff on this unit. Because of the high numbers attending this facility, patients often waited for triage Despite the unit treating up to 10,000 children a year, there was only evidence of one emergency nurse practitioner having their advanced paediatric life support (APLS) training, and no evidence of other staff members (either medical or nursing) having specific training in providing care to children. Paediatric cover was provided from Heartlands Hospital.

Medical care (including older people's care)

Requires improvement

The service uses the DATIX incident reporting system, has regular ward meetings and good education boards, the meeting in which doctors in training receive feedback and learning from others. The environment was fit for purpose. However, some clinical areas were cluttered. There was good evidence-based practice and dementia champions were in place. The high dependency bay was reduced from four to three beds in recognition of the capacity of the available resources. The short-stay medical assessment unit, located next to A&E but part of the medical unit, was treated as a medical A&E accepting patients from the ambulance service. The A&E team had patchy communication with the medical assessment team. There were development opportunities for staff, and the leadership was focused on the needs of patients. Overall, the team appeared to be proactive. However, the profile of the service within the trust appeared low.

Surgery

Good

The surgical service at Solihull Hospital only carried out routine operations and did not provide any emergency surgery. The service had a positive feel, which was in line with patient feedback. We saw that there was a supportive culture, and this was confirmed by staff. There was a single process across the

Summary of findings

whole service, with good cross-site working .However, it was perceived by staff that the service fell below the trust's radar because it was not causing any issues. Interpreters were available, but the timing and booking of these could cause delay.

Surgery at Solihull Hospital was safe because there were systems and processes in place to reduce the risk of complex surgical procedures or unacceptable risks to patients having surgery. We found that documentation was completed and patients understood the treatment they were having. Services were responsive to the needs of patients and patients felt that they received good care.

Intensive/critical care

Requires improvement

Following concerns raised by the Quality Safety Group last year, the high dependency unit had closed and the activity transferred to the critical care unit. As mentioned previously, this can admit one patient with high dependency needs. The only training the nursing staff received in looking after these potentially very unwell patients was through a short rotation to the Birmingham Heartlands Hospital. We were concerned that this solution did not provide enough training for the nursing staff on this unit. The staff said that they felt able to cope with cardiology patients, but were also expected to care for complex surgical and medically unwell patients, for whom they had less experience of nursing. The unit also monitored the heart rate and rhythm of up to six patients on the cardiology ward. On the evening we inspected, we found that there were only two nurses on duty in the unit. This meant that, while they were busy providing care, there was no one to observe the monitors. There was a central 24-hour, seven-day a week critical care outreach team to support the medical and surgical wards. The team provide support to staff looking after critically ill patients, but it did not provide support for nurses in the critical care unit or routinely review patients there.

Maternity and family planning

Good

The maternity service provided at Solihull Hospital was a midwifery-led service and only undertook low-risk births. The unit portrayed a sense of calm, with a positive team approach. There were no staff vacancies at the time of the visit. There had been one serious incident in recent months issues from this had been addressed by staff. Patients were happy with the care and had specific midwives. There were good processes and staff were involved in developing guidelines. However, the cascade process for information was not always robust. The unit operated strict admission criteria, which reduced the risk of women with complex pregnancies being admitted and therefore having a safer birthing experience. Patients were offered choice, and response to the Friends and Family Test was positive. We noted, however, that choice applied only to the Heart of England Foundation Trust sites (limiting real choice). Families were involved and a mother and baby event was demonstrated. Focus groups with interpreters were available.

Summary of findings

We noted that there was an open door leadership style and a strong governance framework. However, we were concerned that this may not be cascaded to all staff. We also noted areas of poor communication.

Outpatients

The outpatients department at Solihull Hospital was described by patients as good. Patients reported that they could get an appointment and that staff were friendly. Some told us that one had to wait a long time to be seen in outpatients, because there was a block booking system in place.

Good

Summary of findings

What people who use the trust's services say

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they needed similar care or treatment. The results have been used to formulate NHS Friends and Family Tests for A&E and inpatient admissions.

The trust scored 68, out of a possible score of 100 in the August inpatient Friends and Family Test, significantly below the national average of 72, with a response rate of 19% as opposed to 29 % nationally. The trust scored 35 out of a possible score of 100 for the A&E department, again significantly below the national average of 64. The response rate was 15.1% for the department, which was above the national average of 11.3%.

The trust can be seen to be performing below the national average in inpatient scores and A&E scores. This results in an overall score of 46, 19 points below the national score of 63.

Areas for improvement

Action the trust MUST take to improve

Ensuring that the staff are appropriately trained to undertake the regulated activity particularly in the critical care unit.

Action the trust COULD take to improve

While most of the wards and areas at the hospital were described by patients and staff as good, the trust does need to address the confusion about the services it provides in respect of A&E and critical care. Specifically, it needs to address:

- Public perceptions of the service provided, especially in relation to children.
- Resources and support from other hospitals in the trust.

Good practice

Our inspection team highlighted the following areas of good practice within the hospital:

- The availability of a 3D scanner for people who had lost their unborn baby.

Solihull Hospital

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Ian Abbs, Medical Director, Guys and St Thomas NHS Foundation Trust

Team Leader: Fiona Allinson, Care Quality Commission (CQC)

The team of 35 included CQC inspectors and analysts, doctors, nurses, patient representatives ('experts by experience') and senior NHS managers.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Before the inspection, our 'Intelligent Monitoring' system indicated that the Heart of England NHS Foundation Trust was a medium-risk trust. It had a longstanding history of struggling with its turnaround times in the A&E department.

We held four focus groups arranged by volunteer organisations and spoke to a wide range of people who shared their experience of the trust with us. Some of the issues they identified were that staff were caring despite being busy, information from the trust was not always in an acceptable format, and difficulty navigating systems within the trust. We used this information during our inspection.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning

Detailed findings

- Children's care
- End of life care
- Outpatients

However at this site there is no dedicated children's service or end of life service Therefore we have not reported on them in this report.

Before visiting, we looked at a variety of information we held about the trust and asked other organisations to share what they knew about it. We carried out an announced visit between 11 and 15 November 2013 and during our visit we held focus groups with different members of staff as well as different groups of people who used the services. We also held three listening events. We looked at patient records of personal care or treatment, observed how people were being cared for and talked with people who used the services. We talked with carers, family members and staff, and we reviewed information that we had asked the trust to provide.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

Most of the services on the Solihull site were delivering care that was considered to be safe.The area of the medical assessment unit was found to be safe at the time of the visit in terms of patients attending and staffing available within the area but this could quickly become unsafe if a patient who did not fulfil the criteria walked in off the street. The critical care unit was also considered safe at the time of our inspection but the lack of training and experience of staff and the types of patients admitted could potentially become unsafe. We judged that the services provided at the A&E were that of a minor injuries unit and as such were safe however we were concerned about the number of children the department saw without having a paediatrician as part of the medical team and limited supply of resuscitation equipment available for children on site.

Our findings

Staffing

We found that the staffing at Solihull hospital was appropriate to the needs of the patients in most departments.

Equipment and environment

We found the emergency services at Solihull Hospital confusing because all the road signs we noted on our visit to and from the unit directed the public to Solihull A&E. As such, the public information set this unit as an A&E service, but we found that in reality only a minor injuries unit operated, which we considered safely resourced and run. However, an acute medical unit (AMU) is on site that received ambulances and emergency medical patients and was run as a medical A&E unit. The local ambulance service was aware of the limitations of the services provided and thus diverted patients with non-medical conditions (that is, patients with suspected surgical complaints, children and trauma patients) to Birmingham Heartlands Hospital. This department, while safe on the day we visited, had a lack of resources to be a medical A&E, was not staffed as an A&E (that is, it was run by medical doctors and nurses without specific A&E training) and did not undertake the monitoring that we would expect an A&E would. Unlike all A&E departments across the country the, AMU department is not 'on the clock'. This means that they are not accountable to see and treat their patients within 4 hours. Although the standard operating procedure states that any patients who are in the unit for longer than 4 hours should be moved to a separate area (called AMU 2), when we visited, this area had been closed because of a lack of available nursing staff. Many of the patients we saw in the unit had been there longer than 4 hours, and it was not clear how this was being monitored on a daily basis. Doctors we spoke to said it was not uncommon for patients to wait longer than four hours to be seen, and, although we had no direct evidence that this was unsafe because they would have regular observations performed, this was not a responsive or patient-centred service. Ambulances were sent to the unit with patients with chest pain and could potentially arrive with a condition that required surgical treatment when no complex surgery was undertaken at the unit and would be transferred to another hospital.

While no complex surgery was carried out at the hospital, this three-bedded area provided level 2 care for two cardiology patients with one bed identified as a high dependency bed (suitable for patients requiring more intensive monitoring or single organ support. Although the staff were skilled at looking after cardiology patients, they did not appear to have had sufficient high dependency training for the type of patients that potentially could be admitted to the unit. The unit also admitted surgical patients who had patient-controlled or epidural anaesthesia. Patients were seen on a daily basis but, on the day we visited, we found that notes were not always clearly transcribed, and staff were unclear as to who had written them and what time they had been reviewed. We also noted on our unannounced inspection that only 11 of the 25 members of staff on the list to have their competency training package completed had signed to state that they had begun working on this. A responsibility of the nurses on the critical care unit was also to observe the electronic monitoring of up to six patients on an adjoining ward. However, this was not always possible when providing care to patients within the critical care unit. Staff working at the Solihull site told us they were only given one opportunity to rotate within the wider critical care directorate, but that this was only for one week and it was not clear if it was a regular event or a one off

Learning from incidents

The trust had reported five 'never events', which are events that should never happen. Two of these were reported at

Are services safe?

Solihull Hospital which we followed up. We reviewed the mechanisms for collecting information on incidents and accidents. We found that there were systems and processes in place that were familiar to all staff for the reporting of incidents or accidents. The investigation of these was done at a local level and reported through the governance committee structures to senior managers. Lessons to be learnt were fed back to staff – for example, in team briefings, and notifications attached to wage slips. When asked, staff were able to describe to inspectors some of the lessons learnt.

Are services effective?

(for example, treatment is effective)

Summary of findings

Services demonstrated good evidence-based practice, with staff involved in developing protocols and guidelines. There were dementia champions in some areas.

Our findings

Evidence-based treatment

Before we inspected Solihull Hospital, we reviewed the large amount of information we held or the trust had sent to us. This information highlighted that the trust was meeting its targets within the A&E department at Solihull Hospital despite failing these targets elsewhere in the trust. This was because the A&E unit was currently performing as a minor injuries unit and medical emergencies went through the acute medical unit, which was not part of these key targets.

Our inspectors reviewed this data and spoke to staff and patients. They found that staff were aware of the never events at other hospitals and were currently using the systems that the trust had put in place to address these and prevent such events from reoccurring at Solihull Hospital.

We looked at the waiting times in the A&E department and found that patients were initially triaged by the receptionist but that this had little impact on the length of time it took to treat patients. We found that patients who walked into the unit were treated quickly and, on the whole, received treatment in a timely manner. However, we did see one person on our unannounced inspection who was waiting for several hours for transfer to the Birmingham Heartlands Hospital. This patient had been seen earlier that morning by the on-site GP who had told him to return if his abdominal pain had not settled. He was then seen by the medical team and subsequently referred to the surgical team at Birmingham Heartlands Hospital. He had been accepted by them and a bed was available; however, he had been waiting over 4 hours for an ambulance to transfer him. The staff in the acute medical unit were unable to tell us when he would be transferred.

Training

We could not be sure that the critical care unit met the needs of its patients when they were not cardiac in origin. This was because of the lack of signed-off competency of staff and the anxiety that staff expressed when looking after these types of patients. The trust needs to review these issues in order to provide an effective service to its patients. Because it does not provide intensive care support, it does not submit data to the national ICNARC audit. The trust needs to be able to reassure itself that it knows whether or not the standard of care is effective.

Are services caring?

Summary of findings

Patients reported positively that the services and staff were caring and focused on the needs of patients. The trust is below the national average in the Friends and Family Tests introduced in both A&E and inpatients.This means that patients the numbers of patients who were likely to recommend the trust to a family member or friend was low. This was in contrast to the positive feedback from patients during the inspection, who felt that, overall, care was responsive and provided in a sensitive and dignified manner, despite caring staff being busy. Staff we spoke to offered patient-centred care.

Our findings

Patient experience

The trust's friends and family test results are below the national average for trusts in England. Response rates at the trust are low although those within the inpatient survey show a steady increase across the months reviewed. However the scores for inpatient remain consistently below average

Five wards were identified by patients as 'extremely unlikely' to recommended to friends and family. At Solihull Hospital this related to ward 15. We visited this ward during our inspection and we were not concerned by the care given on this ward.

Patient-centred care

In all the wards and departments we visited, patients said that they felt staff cared for them. This was supported by talking to patients and their relatives at the listening events during our inspection. Without fail, patients said that staff were caring but very busy; however, even when patients had to wait for care and treatment, most were fully informed of why they were waiting.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Services at Solihull Hospital were responsive to patients' needs. Focus groups were held and interpreters were available. The way services were configured had been adjusted based on the ability of the service to respond to people's needs. We saw posters showing how the hospital had responded to feedback from patients and in one instance had invested £150,000 in building five cubicles and a larger waiting room.

Our findings

Access

The trust was meeting the targets set around the time it takes for a patient to be referred by their GP to having treatment. Patients could choose to use the outpatient services at Solihull Hospital in order to be seen quicker. The Department of Health monitor the proportion of cancelled elective operations. This can be an indication of the management, efficiency and the quality of care within the trust. The trust was performing similar to expected in comparison with other trusts.

Discharge planning

Staff were able to talk about the challenges that the hospital faced. The greatest of these was the pressure on the A&E departments at other hospitals such as the Birmingham Heartlands and Good Hope hospitals. However, the issue of bed shortages still had an impact on the Solihull site. Staff spoken to were aware of the need to ensure that the procedures for patient care (known as pathways) were followed and that timely discharge of patients was undertaken in order to free capacity. The use of the E-JONAH system was widely reported to have helped identify when patients were ready to go home, and then bring other support staff together to arrange discharge.

Complaints

Patients were very complimentary about the services provided at Solihull Hospital. They felt involved in the decisions taken about their care. At the listening events, patients and their families told us that sometimes they did not feel consulted about the changes that were occurring at the hospital. Occasionally they reported feeling that the services at their local Solihull hospital were reduced without consultation. However, on exploration, these people accepted that the trust did try to engage with the local community as to proposed plans.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

There were clear examples of some good leadership at this hospital. However, the senior management team was not always visible on site. We saw there were proactive teams with a strong culture. There was a concern that communication and the cascade of information may not be reaching all staff. The lack of clarity over the extent of some of the services indicated that they may have fallen 'below the radar'. However we saw that active steps were being taken by the trusts leadership team to manage the issues we have highlighted at the trust and that they were already in progress prior to our visit. We saw a visible sense of diversity among the staff.

Our findings

Leadership and vision

We found that many staff were aware of who their matron was and received support from that person. A number of staff spoken to were also able to identify the senior management team on site. There was a strong sense of location and they had worked at the hospital for a long period of time. This meant that they were very familiar with the way in which the hospital was run and knew whom to talk to within each unit. However, they commented that they did not see other senior managers on site often.

Risk management

Staff knew how to raise concerns in respect of risks to patients. The senior team were visible within the hospital and could address issues raised by the staff. We found one exception to this which was the maternity unit who were unsure of how to raise issues. Issues of capacity were dealt with by the senior nursing team during the day and by a single nurse practitioner over the night. This worked well as the senior nursing team knew the site very well and were good at communicating issues to the other sites. We saw good examples of effective decision making among this team.

We saw that the trust had a multilevel governance system for addressing issues at local, directorate and trust wide levels. We saw examples of issues that had been raised and lessons learnt fed back to staff and practice changed as result of this.

Requires improvement

Accident and emergency

Safe	Not sufficient evidence to rate
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good

Information about the service

The adult emergency department last year saw 35,901 patients. The paediatric emergency department was responsible for seeing and treating approximately 8,758 children during a year.

The department is staffed by a middle grade doctor 24 hours a day and a consultant is on site between 8am and 5pm. Senior advice is available from the Heartlands site. In addition there were 12 emergency practitioners available in the department supported by three healthcare support workers in any 24 hour period.

Summary of findings

The signposted A&E service saw about 35,901 adult patients a year; and 8,758 children. There were good policies and good team working by the staff in the unit. As a minor injuries unit, it was safely resourced and run. However, it does not have the resources of an A&E unit. The unit has medical cover from 8am to 8pm, after which cover is provided by an on-call system.

The current arrangements for A&E services at Solihull Hospital is in effect a minor injuries unit and a bearing an A&E sign. The department does not accept patients by ambulance unless to the Medical Assessment Unit as It has no capability to treat major trauma. However, there was significant potential for major trauma patients to arrive other than by ambulance as patients walk in to the A&E department. These patients would then be stabilised and sent to a trauma centre. Staff reported that, at times, trolley patients overflowed from the acute medical unit into the A&E unit where they would be looked after by the nursing staff on this unit. Because of the high numbers attending this facility, patients often waited for triage Despite the unit treating up to 10,000 children a year, there was only evidence of one emergency nurse practitioner having their advanced paediatric life support (APLS) training, and no evidence of other staff members (either medical or nursing) having specific training in providing care to children. Paediatric cover was provided from Heartlands Hospital.

Requires improvement

Accident and emergency

Are accident and emergency services safe? Not sufficient evidence to rate

Staffing

The A&E department is staffed predominantly by an emergency nurse practitioner with a middle grade doctor cover and Consultant cover between the hours of 8am to 5pm. It does not receive ambulances and at its peak has six staff on duty. This number falls to one medical member of staff one emergency practitioner and one healthcare assistant overnight. While this is sufficient for people attending the department with minor injuries it is not sufficient for anyone walking in or being brought in privately with a serious condition. The staff described episodes when people with major trauma were delivered to the department by private car. In such circumstances, the staff treated and stabilised them before transferring them out to Birmingham Heartlands A&E. Staff commented, "At times, this is unsafe; we are overwhelmed by the number of patients. This needs to be called a minor injuries unit." There is currently a consultation being undertaken by the Clinical Commissioning Group and the Trust to review the urgent care provision in Solihull. The trust have mitigated the risk to patients through the provision of an intensive care bed and transfer arrangements to other hospitals.

Equipment and environment

The resuscitation room was physically isolated from the main department; it was actually the domain of the medical assessment unit. The access to the room was restricted by swipe card access. We were told that this was to prevent members of the public entering it unobserved. On our first visit, the advanced clinical practitioner was working in the department on short notice. This member of staff normally worked at one of the other two A&Es in the trust, but this happened about once a month. They could not access the resuscitation room without borrowing an access card from another member of staff.

This department was included in the trust-wide major incident policy. We saw appropriate major incident equipment, including triage cards and a chemical decontamination tent. It was concerning, however, as to whether a department with staffing as low as two practitioners could cope as a receiving hospital in a major incident.

Services for children

When a patient, particularly a child, was taken into the resuscitation room, this could leave other patients in the department without trained nurses to assess them or observe them. Children were seen in this department, although it was not supported by a paediatrician. Staff told us that many local families used it for sick children. We were told that, on average, staff saw one seriously ill child a day. In the last three-week period before our visit, the department saw 599 children, 99 of whom presented with illness, not injury. Of these, 10 had to be transferred to Birmingham Heartlands Hospital. There was no separate area for children to be seen in and they were not being seen by nurses (or doctors) trained in paediatrics. In the case of an emergency, a paediatrician would come over from Heartlands ('within 30 minutes'). Sick children must be stabilised before being transferred. However, the facilities for doing this were limited.

Learning from incidents

The trusts A&E departments reported less than 2%of the total number of serious incidents reported by the trust. These notifications are classified by the degree of harm: no actual harm, low, moderate, severe, abuse and death. This is a lower than expected proportion of the overall number of incidents reported. . From 1 April 2010 it became mandatory for NHS trusts in England to report all patient safety incidents. Between July 2012 and June 2013, the trust submitted 20 patient safety alerts which were classified as deaths, three of these occurred in the A&E department Five deaths were categorised, by the trust, as delay or failure to monitor and four were either a wrong diagnosis or were a delay/failure to diagnose. The remaining death was affected by a lack of handover and communication after transfer. This data also shows that 13 serious incidents occurred in the A&E departments of the trust.

Requires improvement

Accident and emergency

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Evidence-based treatment

The current system was dependent on the skills of the individuals (who may be very capable) rather than any agreed process. We saw good policies and protocols for use in the department. These appeared to be followed by the staff working there.

Training

Safeguarding training and knowledge appeared good. Only one member of staff, an emergency nurse practitioner, was trained in advanced paediatric life support (APLS). Effort had been put into making the area child-friendly, but the department did not consistently have the support for seriously ill children.

Are accident and emergency services caring?

Good

Patient experience

In August 2013, 1,940 people completed the Friends and Family test for A&E. 79.8% of patients were either likely or extremely likely to recommend the service. The trust scored 35 out of a possible score of 100 for the A&E department, significantly below the national average of 64. The response rate was 15.1% for the department, which was above the national average of 11.3%. Data from the adult inpatient survey showed the A&E service as being comparable with other organisations.

Patient-centred care

The patients we spoke to reported that the departments on the A&E site were caring. They felt that staff kept them informed of what was going on and offered them refreshments if they were there a long time.

This department appeared to fully use the skills of the emergency nurse practitioners and advanced clinical practitioners in order to deliver care to patients.

There were positive patient responses to the services they were receiving.

Observation

The nursing staff in the medical assessment unit were seen to book in patients from the ambulance crews and also those who walked into the department. This meant that time taken on this task was not spent on assessing, treating or caring for patients within the department.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access

The department saw about 45,000 patients a year, of whom over 8,500 were children. If a sick child were identified, staff would call in the A&E consultants and the paediatric consultant in order to stabilise them and order their transfer to Birmingham Heartlands Hospital. Staff described 10 paediatric transfers in a 10-week period.

Road signs in the area indicated that Solihull had an A&E department. All the staff we spoke to stated that this was concerning. People visiting or passing through the area would attend Solihull A&E thinking it had major facilities. Signs around the hospital also referred to the 'accident and emergency'. These signs could be a contributory factor to this department seeing large numbers of sick children and adults.

Treatment of vulnerable patients

There was an intensive care bed that was behind locked doors. This was used as a retrieval bed only – that is, if someone needed to be ventilated, the on-call anaesthetist would intubate them. They would then be transferred to the intensive care bed and supervised by the critical care outreach nurse who was also on-site 24 hours a day, seven days a week. An ambulance would then be called to transfer the patient to Birmingham Heartlands Hospital. The anaesthetist would not leave Solihull Hospital at any point, so, if the patient needed to be accompanied by a medical member of the team, then Birmingham Heartlands Hospital would send a doctor over.

Requires improvement

Accident and emergency

Discharge planning

Staff reported that, at times, trolley patients from the medical assessment unit overflowed into this minor injuries unit. Because of the number of patients in cubicles, staff said that patients often waited to be triaged. Patients referred to the acute medical unit (by a receptionist or the minor injuries unit) were not counted as part of the four-hour wait targets in A&E. This meant that there was no four-hour waiting time for patients, and they could wait even longer for treatment or a hospital bed. The medical team acknowledged that there could be a long wait for people to be seen, and that a significant number of them would be sent home. The inspection team felt that this area was being run as a medical A&E unit rather than a true medical assessment unit.

Are accident and emergency services well-led?

Good

Leadership and vision

Staffing and lines of responsibility appeared unclear. Staff we spoke to appeared well informed and acted well as a team. They all expressed frustration in that they felt they were working in a de facto minor injuries unit but that this was not recognised by the trust. They reported that there was no apparent reaction to concerns expressed about this by patients or staff. However in discussion with senior trust staff we learnt that there was a consultation currently being held in respect of the urgent care services in Solihull. Therefore the trust are addressing this issue and have systems in place to mitigate the risks to patients.

Requires improvement

Medical care (including older people's care)

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

We reviewed the Solihull medical care service predominantly on the visit on 15 November 2013. Medical care wards are designated as wards 8, 10, 12, 17, 18 and 19. We visited all these wards and the medical assessment unit (short stay). We undertook an unannounced visit to the acute medical unit, medical assessment unit and the critical care unit on the evening of Saturday 23 November 2014.

Summary of findings

The service uses the DATIX incident reporting system, has regular ward meetings and good education boards, the meeting in which doctors in training receive feedback and learning from others. The environment was fit for purpose. However, some clinical areas were cluttered. There was good evidence-based practice and dementia champions were in place. The high dependency bay was reduced from four to three beds in recognition of the capacity of the available resources. The short-stay medical assessment unit, located next to A&E but part of the medical unit, was treated as a medical A&E accepting patients from the ambulance service. The A&E team had patchy communication with the medical assessment team. There were development opportunities for staff, and the leadership was focused on the needs of patients. Overall, the team appeared to be proactive. However, the profile of the service within the trust appeared low.

Requires improvement

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Staffing

The trust had put in place easier access to recruiting band 5 and band 2 posts. These were junior staff nurses and healthcare assistant posts. However, there continued to be a freeze on administrative posts, which, according to staff working in the area, would, if lifted, free up nursing time to care

Staff confirmed that the staffing arrangements and skill mix were safe. Additional staff were available during the busy afternoon and evening periods in the medical assessment unit. In the acute medical unit on the first floor, the staff reported that, while only 20 beds were funded, there were 26 beds available. The staffing numbers had been increased to ensure that the staffing level was safe, and an additional 12 nurses had been employed. When we visited on the evening of Saturday 23 November, we saw that the staffing levels matched the needs of the patients on the ward.

Environment

The manager had identified improvements to the environment that would provide additional space and leave the ward less cluttered, but it was unclear whether this request had been accepted.

Learning from incidents

Staff told us that 'lessons learnt' throughout the hospital were included on the hospital intranet.

Are medical care services effective?
(for example, treatment is effective)

Requires improvement

Training

Staff received an induction and some further training to critical care nursing. All nurses then undertook introductory modular training that included critical care competencies on which they had to be assessed as competent before they completed their induction. We saw that only 11 people of the 25 staff identified as needing to have their competency package signed off had started the learning package.

Clinical audit

The department used nursing care indicators (including pain management, record of observations and infection control) and were audited by the senior nurse against these indicators monthly. The results of the audit were on notice boards in the clinical area. We were told that the audit included 'commode cleanliness'. We reviewed the short-stay medical assessment unit and noted that it had scored poorly. The ward manager told us that they had arranged training for all staff in effective cleaning and that the following month the score was 100%.

Are medical care services caring?

Good

Patient experience

The trust's friends and family test results are below the national average for trusts in England. Response rates at the trust are low although those within the inpatient survey show a steady increase across the months reviewed. However the scores for inpatient remain consistently below average.

Patient-centred care

The ward manager (short-stay medical assessment unit) had been nominated for an award by a deceased patient's family – the patient had received a terminal diagnosis, their daughter was pregnant and the ward manager arranged for a 3D scan of the unborn baby for the patient to see before they died. There was an article in the local newspaper in October 2013.

Observation

We observed all staff to be kind and caring. Staff we spoke to were not only caring but highly passionate and motivated to provide good care to patients and their families. We observed positive interaction and humour between patients and staff. On our evening visit, the patients we spoke to said that they couldn't praise the staff highly enough; this reflected the comments we heard during our announced visit.

Requires improvement

Medical care (including older people's care)

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Access

The short-stay medical assessment unit contained 26 beds although only 20 were funded – all were used. However, during our unannounced visit on the evening of Saturday, 23 November 2013, we found that patients had remained in the medical assessment unit overnight because there were not enough beds available in the unit.

The 'ambulatory' care area was to be available for use in the following few weeks and would provide an additional capacity of four reclining chairs for people who did not need to either visit the unit for short-term treatment or return for other diagnostic tests such as scans.

The ability for a trust to conduct safe and timely discharges is important for overall patient flow through the hospital. Patients need to be discharged when ready and any information and support provided to ensure the patient does not need to be re-admitted into hospital. In the most recent patient survey the trust scored similarly to other trusts in respect of the information and timeliness of discharge.

Treatment of vulnerable patients

Staff told us that they supported colleagues on the wards with seriously ill patients and records we saw confirmed this.

Are medical care services well-led?

Good

Leadership and vision

Staff reported good team working and a supportive management. On our evening visit, we found that the two new nurses were not being supervised through a preceptorship programme but were receiving support from staff on another ward. There appeared to be confusion at times as to which directorate covered which areas. The staff perceived this as demarcation because staff from other directorates did not help out others in need. An example of this was a receptionist in A&E refusing to log patients from ambulances onto the hospital computer system.

Cohesion

The wards we inspected reported that regular ward or department meetings were held; staff said that they were informed of these and also that incidents were discussed during the meetings. Discussions with staff confirmed that both the downstairs medical assessment unit and the upstairs short-stay acute medical unit were well-led and provided appropriate support.

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good

Information about the service

At Solihull Hospital we visited wards 14, 15 and 16. We also visited the day surgery unit, the pre-admission assessment unit and the surgical assessment unit.

Summary of findings

The surgical service at Solihull Hospital only carried out routine operations and did not provide any emergency surgery. The service had a positive feel, which was in line with patient feedback. We saw that there was a supportive culture, and this was confirmed by staff. There was a single process across the whole service, with good cross-site working .However, it was perceived by staff that the service fell below the trust's radar because it was not causing any issues. Interpreters were available, but the timing and booking of these could cause delay.

Surgery at Solihull Hospital was safe because there were systems and processes in place to reduce the risk of complex surgical procedures or unacceptable risks to patients having surgery. We found that documentation was completed and patients understood the treatment they were having. Services were responsive to the needs of patients and patients felt that they received good care.

Good

Surgery

Are surgery services safe?

Good

Staffing

During our visits to Solihull Hospital we found that there were the appropriate number of staff on duty to care for the patients on each ward.

Equipment/ and environment

Staff reported and we saw that there was enough equipment for patients to ensure that they received the care they required.

Learning from incidents

Staff were able to describe how they were kept up to date with information about changes to practice in the trust. The site had had two never events during the last year and these had been appropriately investigated. Staff explained how they implemented the World Health Organization's safe surgery checklist to reduce the risk of never events. This was used within every theatre suite.

Are surgery services effective?

(for example, treatment is effective)

Good

Evidence-based treatment

Patients' medical needs were assessed appropriately in the surgical admissions unit and this reduced the risk of unsafe or inappropriate care. Records were fully completed and risks clearly identified. These included risks relating to malnutrition, pressure damage to skin, falls, moving and handling, and use of equipment, although these may not all be necessary if patients were discharged the same day. We found that each patient had an appropriate plan of care to manage their risks.

Training

Staff had appropriate skills and training, and their competency was regularly monitored. On each of the wards we visited, staff were professional and competent in their interactions with patients. They told us that training opportunities were tailored to meet the needs of the patient group. For example, there was a urology treatment centre and catheter clinic on the urology surgical ward.

Working with others

We were told about a 'joint school' hosted at Solihull Hospital, where patients and their family met the occupational therapist and physiotherapist who ran sessions to support patients before, during and after their knee or hip replacement treatment. Patients from across the three hospital sites could access this service.

Are surgery services caring?

Good

Patient experience

The trust's friends and family test results are below the national average for trusts in England. Response rates at the trust are low although those within the inpatient survey show a steady increase across the months reviewed. However the scores for inpatient remain consistently below average.

Of 56 inpatient wards participating in the surveys at the trust, 27 scored below the trust-wide average of 68.

Five wards were identified by patients as 'extremely unlikely' to recommended to friends and family, none of these related to surgery at Solihull Hospital.

Patient-centred care

All the patients we spoke to commented on the kindness of all staff involved in their care. One patient said, "They (the staff) are all compassionate, friendly and caring." Patients told us they had adequate nutrition and hydration. One patient said they were very happy with the meals and described them as being "small, tasty and well-presented". The care records we examined contained evidence that patients had been involved in planning their care. Patients told us they had been able to discuss their surgical procedure and aftercare when they were admitted to the ward. Patients told us that staff had explained the procedures they would be having and their post-operative care. All felt involved in the treatment plans.

Observation

We saw an isolated incident on one of the surgical wards where a healthcare assistant referred to a patient by their bed number in that patient's hearing.

Good

Surgery

Are surgery services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access
The trust was meeting the targets set around the time it takes for a patient to be referred by their GP to having treatment. The Department of Health monitor the proportion of cancelled elective operations. This can be an indication of the management, efficiency and the quality of care within the trust. The trust was performing similar to expected in comparison with other trusts.

Treatment of vulnerable patients
Staff had a good understanding of how to protect patients from abuse and restrictive practices. They understood the types of abuse and knew how to report any safeguarding concerns. They said they were confident that concerns would be appropriately dealt with to ensure that patients were protected. We were told that patients whose first language was not English would have an interpreter booked for the day of their procedure during their pre-operative assessment. However, a nurse on the surgical assessment ward told us that the interpreter did not usually arrive at the hospital until about 8.30am although the patient may have been admitted for their procedure at 7am. This meant that the expected theatre list was not always followed and a patient who may have expected to be first on the list might not be taken down until later in the day.

Are surgery services well-led?

Good

Leadership and vision
The senior nursing staff said they believed the trust had a good culture of reporting incidents and concerns. They also said they were confident that they were listened to and their views taken into consideration.

The ward managers told us they had regular contact with their matrons and said they felt supported in their roles. One ward manager told us the trust had a variety of ways of keeping staff informed of what was happening in the trust. For example, they told us they had daily briefings, staff meetings, newsletter, emails and the trust's intranet.

Requires improvement

Intensive/critical care

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Good

Information about the service

There was a critical care unit at Solihull Hospital. This unit consisted of three beds and was situated at the end of the cardiology ward. The unit also monitored up to six patients on the cardiology ward. There was no intensive care unit; however, there was a fully equipped intensive care bed available should a patient need one. The critical care outreach team provided support to staff based at Solihull Hospital.

Summary of findings

Following concerns raised by the Quality Safety Group last year, the high dependency unit had closed and the activity transferred to the critical care unit. As mentioned previously, this can admit one patient with high dependency needs. The nursing staff received training in looking after these potentially very unwell patients through a short rotation to the Birmingham Heartlands Hospital. We were concerned that this solution did not provide enough training for the nursing staff on this unit. The staff said that they felt able to cope with cardiology patients, but were also expected to care for complex surgical and medically unwell patients, for whom they had less experience of nursing. The unit also monitored the heart rate and rhythm of up to six patients on the cardiology ward. On the evening we inspected, we found that there were only two nurses on duty in the unit. This meant that, while they were busy providing care, there was no one to observe the monitors. There was a central 24-hour, seven-day a week critical care outreach team to support the medical and surgical wards. The team provide support to staff looking after critically ill patients, but it did not provide support for nurses in the critical care unit or routinely review patients there.

Requires improvement

Intensive/critical care

Are intensive/critical services safe?

Requires improvement

Staffing

There were three staff on duty in the Critical Care Unit (CCU) to attend to the patients that were using the unit. Patients needing medical treatment were treated on the unit. All patients were receiving appropriate care at the times of the inspection visits. There was a doctor on call for cardiology and an anaesthetist for other patients in the unit.

Equipment and environment

On the evening of our unannounced visit, there was a patient who had been admitted for intermittent continuous positive airway pressure (CPAP). They had been seen that day by the 'intensive care' doctor. There was no documentation of what time they had been seen or the grade of the person who had seen the patient. There was no way of identifying the person who had reviewed the patient because they had not used the 'daily HDU [high dependency unit] record', which is a proforma that had been used on every other day of the patient's stay. When the nurses were questioned about this, they said that the doctor was new and didn't know that they were meant to use this.

Are intensive/critical services effective?

(for example, treatment is effective)

Requires improvement

Training

The unit is a four bedded combined coronary care and high dependency care unit located at the end of a ward.It is flexible to take all sick patients within the hospital. Nursing staff were trained by a short rotation to the Birmingham Heartlands Hospital and completing a competency package. However, only 11 of the 25 nurses rostered to work in the unit had started this learning package. The trust had previously been concerned about the level of skills and experience of the staff working in this unit and had arranged the short induction at Heartlands. However, while all the staff had received this training, there was some anxiety about their skills and knowledge in respect of surgical patients requiring critical care support. Staff expressed anxiety in respect of their skills and knowledge base for caring for surgical patients needing critical care.

Are intensive/critical services caring?

Good

Patient experience

The trust's friends and family test results are below the national average for trusts in England. Response rates at the trust are low although those within the inpatient survey show a steady increase across the months reviewed. However the scores for inpatient remain consistently below average.

Patient-centred care

Patients said they felt that they received good care from the staff – that a member of staff was always around and would attend to them in a timely manner.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Complaints

We did not see any feedback systems in place within the unit; therefore, it was unclear how patients of the unit communicated their views to staff or management.

Are intensive/critical services well-led?

Good

Leadership and vision

The staff felt that their managers were visible and provided the support they needed. It was clear, when talking to them, that this unit was not part of the critical care directorate but part of the medical unit. As such, the staff received support from the staff within the medical unit. This concerned the inspection team because the services provided by this unit potentially cut across specialities, but

there was no recognition or support for the level of care provided. Whilst the trust had a training programme for staff in critical care there was little direction for the ward leaders in ensuring that this was completed in a timely manner.

Good

Maternity and family planning

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Information about the service

Solihull Hospital provided midwifery services for low-risk births through a midwifery-led unit. More complicated births were supervised by obstetricians and booked at Birmingham Heartlands Hospital, Good Hope Hospital or another nearby hospital according to the mother's choice. There were approximately 369 births at the unit 2011/2012.

Summary of findings

The maternity service provided at Solihull Hospital was a midwifery-led service and only undertook low-risk births. The unit portrayed a sense of calm, with a positive team approach. There were no staff vacancies at the time of the visit. There had been one serious incident in recent months issues from this had been addressed by staff. Patients were happy with the care and had specific midwives. There were good processes and staff were involved in developing guidelines. However, the cascade process for information was not always robust. The unit operated strict admission criteria, which reduced the risk of women with complex pregnancies being admitted and therefore having a safer birthing experience. Patients were offered choice, and response to the Friends and Family Test was positive. We noted, however, that choice applied only to the Heart of England Foundation Trust sites (limiting real choice). Families were involved and a mother and baby event was demonstrated. Focus groups with interpreters were available.

We noted that there was an open door leadership style and a strong governance framework. However, we were concerned that this may not be cascaded to all staff. We also noted areas of poor communication.

Good

Maternity and family planning

Are maternity and family planning services safe?

Good

Staffing

There were no vacancies and we found the staff were established in their posts and had considerable experience. There appeared to be an abundance of staff during our visit. We spoke to staff who explained a pilot was under way in which community and birth centre staff were integrating and working both within the birth centre and in the community setting. We were unable to speak to women who were using the service because nobody was in labour during our visit. The lead midwife explained that the uptake of the birth centre in recent months had declined from around 30 births a month to 18. Despite this, both staff in the community and specialist midwives told us they still struggled at times because of the lack of administrative support.

Learning from incidents

There was an effective mechanism to capture incidents, near misses and never events. Staff told us they knew how to report both electronically and to their manager. We saw a robust governance framework that positively encouraged staff to report incidents, and information on how to complain was visible to the people using the service. There was also an audit programme. The associate head of midwifery explained that, because of the size of the unit and the low complexity of needs, the audit programme was not as extensive as in other locations within the trust.

Women told us that they felt safe. One woman said, "I have had everything explained to me. I'm glad it's this hospital I'm coming to." Staff also explained to us that they felt the service was safe.

Are maternity and family planning services effective?

(for example, treatment is effective)

Good

Evidence-based treatment

The trust was able to demonstrate to us that policies, protocols and guidance were based on nationally recognised guidelines and standards. We saw the trust had a specialist midwife responsible for ensuring that all clinical effectiveness was embedded in practice, and that all policies and standards were evidence and research based. The trust had robust systems in place for the ratification of new policies and guidance.

We saw regular review, audit and updating of policies and guidance. We spoke to staff and asked them if they were engaged in the development of policies and how new guidance was communicated to them. One midwife explained that draft policies were circulated to staff for comment before being approved at committee level. Once approved, policies were circulated to heads of departments to be given to all staff. We also saw that guidance updates were included in the monthly newsletter.

All relevant National Institute for Health and Care Excellence (NICE) guidance was reviewed by the clinical risk and audit committee. The special midwife for guidelines explained that, when NICE guidance was not implemented, there was always documented evidence to show the rationale behind this decision.

Training

Women were cared for by suitably qualified and competent staff. We saw evidence that staff were able to access a variety of mandatory training and there were opportunities for further development. This training included formal courses, self-directed study and emergency skill drills. A variety of training was available for staff to attend and there were two dedicated training midwives employed. However, when questioned, most staff were unclear what mandatory training should be attended.

We spoke to a maternity support worker who said they were well supported within their role by the project midwife. They were able to support the midwives and the women using the service. They also told us that they felt

Good

Maternity and family planning

they could fulfil their role as a midwifery support worker. We spoke to the project midwife too, who told us their focus was on the continued development and training of support workers.

Clinical audit

We saw evidence that a monthly metric was undertaken on a sample of 10 care records. The clinical risk midwife explained that this in-depth review of care records identified gaps in care, treatment and documentation throughout the antenatal, intrapartum and postnatal period. Performance against the metric standards was reported through the governance committee structure and results were fed back to staff through the staff brief. We saw evidence in the staff brief for September 2013, that results were given to all staff.

We saw a robust governance framework and reporting structure and there were four dedicated governance midwives employed. Incidents, serious untoward incidents, complaints and audits were analysed and reported through the committee structure to the board. However, despite seeing various methods used to communicate the findings and learning to staff, we were repeatedly told staff did not understand the trends, learning and changes to practice.

Are maternity and family planning services caring?

Good

Patient experience

The trust's friends and family test results are below the national average for trusts in England. Response rates at the trust are low although those within the inpatient survey show a steady increase across the months reviewed. However the scores for inpatient remain consistently below average.

Patient-centred care

The women we spoke to in the antenatal clinic told us they were happy with their care. One woman said, "I have received good care here."

All the women and families we spoke to told us they were involved in their care and were able to complete their care and birth plans with the support of a midwife. One woman said, "I am booked to look around the birth centre and go through my birth plan just before I am due. I can also telephone and go in at any time."

Observation

Both the staff and women we spoke to assured us there was a culture of caring. From what we saw and heard, the staff and the people using the service developed a trusting relationship, and the women understood their plan of care and felt involved in the development of it.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Good

Access

The staff we spoke to had a good understanding of the population who used the service and were all able to explain with confidence the requirements of the people who were inpatients.

Treatment of vulnerable patients

Staff had access to interpreters, a list of staff members who spoke different languages and a language line. When asked how useful these services were, they were inconsistent in their responses. Some said that they used the language line; others felt that it did not maintain people's privacy, especially in the reception area. Some staff were not aware of all of the services available. We saw signage in several languages, which demonstrated that the hospital was catering for people whose first language was not English.

The trust had an extensive team of specialist midwives, who supported midwives to care for the more vulnerable people within the community. We saw specialists for bereavement, domestic violence, mental health and female genital mutilation. Many of the specialists told us that they held community events or visited people in their home. We also spoke to community midwives who gave us examples of focus groups in the community that met the needs of the more vulnerable people locally. This showed us that the provider based care around the needs of the population.

Good

Maternity and family planning

Complaints

We saw evidence that the family and friends test was carried out. We saw comment books available for people to write in and the complaint process was available for and explained to women and their families should they wish to make a formal complaint.

Are maternity and family planning services well-led?

Requires improvement

Leadership and vision

We spoke to a number of staff who told us that senior managers and leaders were not visible in the clinical areas and that communication with the most senior midwifery staff was poor. The staff felt that the management was only interested in systems and processes rather than the support of the workforce. However, the staff explained to us that they had invited the head of midwifery to join their team meeting the following week and they had accepted.

Staff told us they felt supported by the associate head of midwifery and we saw a very good senior clinical midwife presence. We saw evidence that 66% of staff had received an appraisal, with a target of more than 75% by the end of the year. Supervisors of midwives were available for support and were on call throughout the day and night. The ratio of midwife supervisor to midwife was slightly higher than the recommended national standard of 1:15. The midwifery support workers were supported by the project midwife and the newly qualified midwives were supported by a preceptorship midwife (this is a midwife with significant experience who supports junior midwives).

Cohesion

Staff told us they did not know how to raise innovative ideas with senior management. When questioned, they explained that they wanted to raise the profile of the birth unit and create a website. However, we spoke to a member of staff in another department who was organising a community event to raise awareness of the unit. We also spoke to a midwifery support worker who had the skills required to build a website. It was difficult for us to determine whether the issue staff had was the escalation of ideas to senior management or a coordinated approach for them to discuss ideas and focus resources.

Good

Outpatients

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Information about the service

The outpatients department at Solihull Hospital offered outpatient appointments for a variety of specialities.

Summary of findings

The outpatients department at Solihull Hospital was described by patients as good. Patients reported that they could get an appointment and that staff were friendly. Some told us that one had to wait a long time to be seen in outpatients, because there was a block booking system in place.

Good

Outpatients

Are outpatients services safe?

Good

Staffing

There were enough staff present in the department during our inspection. We spoke with staff and patients who were using the service at the time of our inspection who told us that they felt safe in the department. We spoke to four members of staff during this inspection. Staff told us the clinics often overran. This included a very busy outpatients' service for women who needed breast care. We were told that appointments were often added on to the usual list. This meant that the day after our visit there were five patients added onto a clinic and they had each been given a 10-minute appointment time. Staff told us this was not enough time and they felt the trust relied on staff goodwill to make sure that all patients were seen and given the time they needed to come to terms with their diagnosis. We spoke to the matron about this, and they confirmed what we had been told and that there was a reliance on staff to work over their hours in order to meet patients' needs.

Equipment and environment

We saw that the outpatients department was clean and tidy.

Cleanliness

There were hand gel dispensers in numerous places throughout the clinic to enable people to clean their hands.

Are outpatients services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Training

Staff working in the department had access to training and we saw that there were sufficient numbers of nursing staff to health care assistants on duty. Staff said they had training to support them in the delivery of their work. In all clinics there was a split of trained nurses, healthcare assistants and medical staff.

Working with others

The trust was meeting the 18-week referral to treatment targets. This means that within 18 weeks of being referred to the hospital by your GP your treatment had begun. This would involve the initial contact with the consultant through the outpatients department. Therefore because the trust was meeting this target it would appear that the outpatient department was functioning well.

Are outpatients services caring?

Good

Patient-centred care

Patients who were waiting for their appointments told us they were happy with the information they had been given by staff. They told us staff had kept them informed about what was happening and when they would be seen.

Staff we spoke to were concerned that clinics were overbooked, and at times they felt this affected how they cared for their patients. They said, "When you get 10 minutes to tell someone really difficult news, it's not good. We all stay late because none of us would leave any patient, but I do think the trust rely on our goodwill too much."

There were volunteer staff on duty to help patients find their way around the clinics and help those who needed assistance.

We saw staff speaking to patients in a compassionate and respectful manner. We were also told that staff regularly stayed longer than their regular hours in order to support the service delivery. Staff said, "We wouldn't leave patients unattended. The management know this and I think there is a reliance on us to do this."

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access

The trust was meeting the targets set around the time it takes for a patient to be referred by their GP to having treatment.

Treatment of vulnerable patients

Information was not readily available for patients whose first language was not English and/or was needed in a

Good

Outpatients

different format such as braille or audio. We did see that arrangements could be made for patients to have such information but they would need to wait for it to be sent to them.

Staff we spoke to understood a patient's right to consent to their treatment. They told us how they supported patients by making sure they understood their care and treatment.

Complaints

We found information about the family and friends test throughout the outpatients department. The card holders were empty, however, which meant that patients could not do the test. We saw information booklets that related to medical conditions. Information about whom to speak to and how to contact them, if patients were unhappy about any aspect of their care, was clearly displayed in the department.

Are outpatients services well-led?

Requires improvement

Leadership and vision

Staff told us they did not see senior staff or the matron in their department but they knew that support was available to them at the end of the telephone. All the staff we spoke to told us they had regular team meetings and this helped with the development of the team and to make sure that important messages were conveyed. Some staff said they were concerned about the gap in leadership once the matron had left their post. No arrangements had been made to ensure senior management of the service.

Good practice and areas for improvement

Areas of good practice

Our inspection team highlighted the following areas of good practice within the hospital:

- The availability of a 3D scanner for people who had lost their unborn baby.

Areas in need of improvement

Action the hospital MUST take to improve

- Ensuring that the staff are appropriately trained to undertake the regulated activity particularly in the critical care unit.

Action the hospital COULD take to improve

While most of the wards and areas at the hospital were described by patients and staff as good, the trust does need to address the confusion about the services it provides in respect of A&E and critical care. The trust needs to address:

- Public perceptions of the service available.
- Resources and support from other hospitals in the trust.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff. Staff were not able to receive appropriate training and professional development to improve the care for patients due to pressures on their nursing time. Regulation 23 (1) (a).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff. Staff were not able to receive appropriate training and professional development to improve the care for patients due to pressures on their nursing time. Regulation 23 (1) (a).

Regulated activity	Regulation
Surgical procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff. Staff were not able to receive appropriate training and professional development to improve the care for patients due to pressures on their nursing time. Regulation 23 (1) (a).