

## Heart of England NHS Foundation Trust

# Good Hope 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.

### 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.**

Good Hope Hospital is the second largest 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, Sutton Coldfield, Tamworth and South Staffordshire. Good Hope Hospital has approximately 521 beds and is a centre for pain management.

We inspected this 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 its 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 yet to have an impact. These included escalation plans, bed management meetings, use of discharge boards to name a few. We did not inspect any community services provided.

This hospital has been inspected seven times under the previous methodology. The first inspection took place in March 2010 and the hospital was found to be meeting the inspected standards. The next inspections took place in April and August 2011 and the latter inspection found the hospital to be not meeting the standard on the management of medicines. Follow up inspections in 2012 found the hospital to be meeting all inspected standards. The last inspection was in May 2013, following previous non-compliance in January. The hospital was meeting the inspected standards.

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 between 11 and 14 November 2013 to Good Hope Hospital. We looked at patient records of personal care or treatment, observed how staff were providing care, and talked with patients,

# Summary of findings

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.

We issued a warning notice to the trust on 20 December 2013 in respect of following national and local guidance and policy. We reinspected to monitor compliance with this notice on 27 February 2014. We found that the trust was compliant in respect of the issues contained within the warning notice. Where this follow up inspection reviewed issues at the trust this report has been updated to reflect this.

The trust scored below average in the Friends and Family Tests introduced in both the A&E department and for inpatients. However, during the inspection, we heard positive feedback from patients who felt that, overall, care was responsive and provided in a sensitive and dignified manner despite caring staff being busy.

In general, we found the surgical and critical care services at Good Hope Hospital to be responsive to the needs of the people it served. However, we were concerned about the nursing staffing arrangements in maternity, children's care, medical care and A&E. These presented in different ways and had different impacts on patients in these areas.

In A&E, the initial triage was not followed up by a medical triage, which had an impact on potentially ill patients not being seen in a timely manner. The care given in this area

was poor because of the time pressures on nursing staff. Within the medical unit, the care given to patients mostly met their needs, but on the acute medical ward (Ward 20) there was a lack of basic furniture such as lockers and chairs, regular nursing staff and security of medicines that led to the service being unsafe. We raised this at the time of our visit with both the senior manager on site and the chief executive of the trust.

On our return unannounced visit in November 2013, the equipment had been put in place. However, the other issues remained unresolved. We issued the trust with a warning notice in this respect on 20 December 2013. We returned to monitor compliance with the warning notice on 27 February 2014 and found the trust to be compliant.

In maternity and in children's care, we found that the shortages of staff had an impact on the care of women and children. Midwives were stretched to deliver good care because there were too few of them on duty, and in the children's services a lack of doctors and staff with appropriate training had an impact on the safety of the service.

The trust was aware that there was a shortage of nursing staff, and that this had had an impact on the care given to patients. It had decided to make it easier to recruit band 5 nurses and band 2 staff by quicker approval of vacancies, and by introducing a rolling programme of recruitment. This was beginning to have an effect in some of the ward areas; however, the full impact of this recruitment programme may not be felt until early 2014. In the meantime, patients and staff said that shortages of nursing staff were preventing people from receiving good treatment and care.

# 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?**

In November 2013, we found a mixed picture of whether services were safe at Good Hope Hospital. Patients in the A&E department were not always assessed in an appropriate manner, and on the newly opened acute medical unit (Ward 20) there was no continuity of staff and there were breaches in regulations relating to safety. In the children's department, we found that services for children and adolescents with mental health issues were not delivered properly. However, we found that surgical services, maternity and critical care services were safe at Good Hope Hospital.

Following our inspection on 27 February 2014 we found that systems and processes had been put in place to address the issues raised within A&E and Ward 20. Patients could be assured of a safer service due to these improvements.

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### **Are services effective?**

Many services across the hospital were providing effective care. However, we saw a lack of risk assessment in the A&E department that could affect patients' care. At our inspection on 27 February 2014, we found that risk assessments were currently in place within the A&E department at Good Hope Hospital. The ward staff knew the pressures on the trust and were aware of the actions taken by it and them in order to resolve these. Training was provided by the trust for staff but ward areas found it difficult to release staff due to the pressures on the ward. This meant that care was not as effective, as staff were not always up to date with their training requirements. An example of this was the lack of uptake on training in dementia care, resulting in staff not fully understanding the needs of patients.

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### **Are services caring?**

Most people we spoke to were positive about their care. Much of the care we observed during the inspection was good. However, in November 2013 we had concerns about the A&E department, the medical and the paediatric wards where care was not always as person-centred as it might have been because of shortages of staff and the pressure staff were under.

Patients were full of praise for staff, although expectations about the level of care were low. The staff themselves wanted to provide a good level of care and often made extra effort to ensure that a particular patient had a good experience. This was very evident on the maternity unit where staff often stayed late to ensure that women had a positive experience of the delivery process.

The Friends and Family test however, introduced by the Government this year, shows that the trust is significantly below the national average indicating that people using the hospital would not recommend it to others.

At our inspection on 27 February 2014 we found that intentional rounding had been introduced to the A&E department and patients could be assured that their basic care needs were now being met.

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### **Are services responsive to people's needs?**

We found that the hospital was not always responsive to meeting the needs of its patients. Although we did see some good aspects of care for example we saw family and friends tests throughout the hospital and in general there was a sign that said, "You said – We did" telling patients and relatives what changes had been made. We also saw that the numbers of staff expected to be on duty were advertised in the ward area so that people could see the numbers of staff available for care and we saw some good practice in respect of children's and maternity services where the staff made an extra effort to ensure that people received a good service at the hospital. However in November 2013 this was outweighed by the delays patients were experiencing in A&E.

At our inspection on 27 February 2014 we found that patients were being seen quicker by a clinical member of the A&E team.

# Summary of findings

## **Are services well-led?**

The senior management team at the trust was relatively new, but displayed an understanding of the issues that the hospital faces. The team was currently facing further changes because the chief nurse was in an acting-up position and the medical director was about to leave. This presented challenges of stability of leadership throughout the trust. However, the decision to treat each hospital as its own directorate was welcomed by staff, because they felt ownership of their hospital and its services. This was nowhere more obvious than at Good Hope, where staff felt that they worked for Good Hope Hospital rather than the Heart of England NHS Foundation Trust. Staff felt that their immediate line managers were supportive but that the senior management team did not visit the hospital often enough.

# Summary of findings

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

### Accident and emergency

The A&E department at Good Hope Hospital was very busy during our inspection in 2013. People who walked into the department were not being assessed by trained staff and this was a risk to their health and safety. There were delays in meeting the four-hour treatment targets as set by the Department of Health. This meant that patients were waiting longer than expected to receive treatment.

We spoke to patients and they accepted the fact that if they attended A&E they would have to wait for a long time. Patients found the department's staff caring. However, we saw episodes when people's privacy and dignity were not respected and care was delayed because of shortages of staff within the department. The trust had an ongoing recruitment programme and the effect of this had yet to be felt in this department.

At our inspection on 27 February 2014 we found that the process for assessing patients had been reviewed and this resulted in an assessment of their need by a clinical person within the recommended 20 minutes. We also found that care needs were being met by staff whilst they waited for treatment.

Requires improvement



### Medical care (including older people's care)

Staff were able to give examples of when they had learnt lessons from complaints or serious incidents, and they saw this as positive. We found that patients were happy with the care that they had received from staff although they acknowledged that they might have to wait for care because staff were busy. The numbers of staff on duty were routinely published at the end of the wards and staffing levels seen during our visit were safe. However we spoke to a number of staff who had been moved from their regular ward to another who did not feel that they had the skills or experience to adequately care for patients on their new ward. At our unannounced visit we went to three wards where dementia patients were being cared for. We found that on each ward the way that night staff managed these patients over night was by moving their beds into the corridor area. While this may reduce the risk of patients falling from their beds it does not enhance their privacy and dignity.

In November 2013, we saw that the acute medical unit (Ward 20) had been reopened to prevent the use of the day surgical unit as an outlier area for patients with medical conditions. However, this unit was found not to be staffed or resourced, and in some areas, such as patient equipment, staffing, medicines management and confidentiality of records, it was unsafe. We spoke to the senior management team at the time of our inspection and saw that action was taken to address some of the issues. We were sent daily bed reports informing us of the number of staff on duty for a week following our visit to this ward. However this daily review did not include aspects of safety such as ensuring that staff had the experience required to care for the patients on the ward.

Requires improvement



# Summary of findings

When we returned for our unannounced inspection, we found that the action taken had not been sustained and that there was little permanent staff allocated to the ward, the medicines storage remained unsafe and patients were not being cared for by staff who had the appropriate skills, knowledge and experience.

At our inspection on 27 February 2014 we found that the issues we had raised had been addressed.

## Surgery

Patients felt that the hospital provided safe surgical services. However, a visitor noted that not all medical staff used the hand sanitisers when entering the ward area. We saw examples of where staff were learning the lessons from incidents. We found that documentation was kept up to date and that patients were encouraged to return to normal as soon as possible after their operation.

Patients told us that they were treated with dignity and respect when in hospital and a system of protective meal times ensured that people were able to eat without interruption. On the day surgery unit, we were informed that medical patients had previously been admitted, which had had a detrimental effect on some surgical patients.

Good



## Intensive/critical care

We found that services within the critical care area were safe. Staffing was at the level required by national guidance and staff were found to be caring and compassionate. Communication flows of information from other areas of the hospital were good and lessons learnt shared with all staff. The support of the critical care outreach team was valued by other staff in the hospital; however, bed capacity in this unit was sufficient for the hospital's needs.

Good



## Maternity and family planning

We found that there was an increased demand in staffing required at Good Hope Hospital to meet the requirements of staff obstetric theatres. We also found that, while the requirement for translation services was less than at Birmingham Heartlands Hospital, there was inconsistent use of interpreting services.

Overall, we found that there was poor visibility and communication from the senior leaders in this directorate. Staff felt that they were managed from afar (Heartlands Hospital) and that management was aggressive. There was good support provided by the modern matron at this unit. Some midwives reported poor consultant presence on the delivery suite; however, there was good team work and peer support. Specialist midwives were available to support vulnerable women within the community. We saw good clinical effectiveness – in particular, the use of research and evidence-based policies and procedures.

Requires improvement



# Summary of findings

## Services for children & young people

None of the parents or patients raised any concerns with us about safety at the hospital. Children's safeguarding procedures were robust and were improved in response to findings from a serious case review. Assessments were done of patients' needs on admission by both nursing and medical staff, and care and treatment were delivered effectively. Parents spoken to were mostly pleased with the care and treatment that the hospital had provided, and positive about the staff.

There was a lack of appropriate response to the management of children with mental health needs and a lack of an effective response to the shortage of permanent senior paediatric doctors (registrar, middle grade), which had an overall impact on the delivery of care. At times there was a shortage of nursing staff with the appropriate skills, knowledge and experience to care for patients. A lack of clarity on the function of the redesigned inpatient service meant that pathways in place were not always followed and the service was not responding to the needs of patients who were admitted.

There was a strong management presence in the form of the head of nursing, matron and supervisory ward sisters. We saw evidence of regular senior meetings and completion of audits to monitor the quality of service provided. There was evidence of learning and improving as a result of incidents that had occurred. Arrangements were in place for the management of high-risk issues that affected the hospital. For example, the hospital had proactively responded to concerns about staff shortages and bed occupancy of the inpatient assessment unit. However staff felt that the focus was on the Heartlands site and that they were marginalised by this.

Requires improvement



## End of life care

Patients received safe end of life care. They had support to make decisions about their care and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patients and their families had positive views about the end of life service. The hospital had worked hard to meet the needs of its local ethnic population and to ensure that the religious and cultural needs of people at the end of their life were met in a timely and sensitive way.

Good



## Outpatients

We found that the department was clean and well organised. The staff were passionate about delivering good quality care. Services were not always responsive to the needs of patients. We had a lay person with the inspection team who could not see. There were no signs in braille and no floor markers to tell blind people where they were. Items were placed along the walls, making it difficult for blind people to access areas. Letters that were requested via email for blind people were not always sent, and, when they telephoned, receptionists asked them for reference numbers, which of course they could not see.

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% in comparison with the national response rate of

29%. 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 was 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

- The initial assessment of patients for treatment provided in the A&E department. This was found to be met at our inspection on 27 February 2014.
- Patient flow throughout the hospital to enable the A&E department to function effectively. This was found to be met at our inspection on 27 February 2014.
- Ensuring patients are cared for on appropriate wards and clinical areas, to ensure effective use of facilities.
- The safety of patients on the acute medical unit (Ward 20) by the creation of a ward team. This was found to be met at our inspection on 27 February 2014.

- The security of medications on the acute medical unit (Ward 20). This was found to be met at our inspection on 27 February 2014.

### Action the trust **COULD** take to improve

- Reduction of the use of agency and bank staff by continuing recruitment of permanent staff.
- Training for staff working with children, adolescents and adults with mental health issues.

## Good practice

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

- The work of the falls coordinator, who supported and trained staff throughout the hospital, was an area of good practice at Good Hope Hospital.

- The bereavement service also provided support to staff and family during a traumatic time. The 'It's the little things' project had shown some benefits to people, and those we spoke to who were recently bereaved felt supported by the trust.



# Good Hope 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; Children's care; End of life care; 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 '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.

We returned to the trust on 27 February 2014 to monitor compliance with the warning notice issued on 20 December 2014 to this hospital in respect of adherence to national and local policy and guidance.

## 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)

## Detailed findings

- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients

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

In November 2013, we found a mixed picture of whether services were safe at Good Hope Hospital. Patients in the A&E department were not always assessed in an appropriate manner, and on the newly opened acute medical unit (Ward 20) there was no continuity of staff and there were breaches in regulations relating to safety. In the children's department, we found that services for children and adolescents with mental health issues were not delivered properly. However, we found that surgical services, maternity and critical care services were safe at Good Hope Hospital.

Following our inspection on 27 February 2014 we found that systems and processes had been put in place to address the issues raised within A&E and Ward 20. Patients could be assured of a safer service due to these improvements.

## Our findings

### Staffing

Staff commented throughout the hospital that they were short of staff. However, in some areas a number of staff were able to tell us that more staff had been recruited by the trust and that in particular band 2 and band 5 staff had become easier to recruit. These bands related to healthcare assistants and junior staff nurses. The management team told us that the process for the recruitment of band 2 and band 5 staff had been improved with people getting into post in a timelier manner. We were also told that the trust had increased its staffing levels to accommodate sickness, training and annual leave. The trust were recruiting 300 nurses. Bank staff, which are staff employed by the trust on a zero hours contract and work to suit their personal lives, are used to fill 85% of the shifts vacant through sickness or annual leave. This has recently dropped to 75% as the trust fills its vacant posts. The full impact of the latest recruitment drive is expected by early 2014.

### Equipment and environment

We found that some items of patient furniture was not always readily available on all of the wards all of the time.

### Medicine management

In most wards and departments we found that the process for keeping medicines secure was functioning well. However on ward 20/AMU we found that medicines cupboards did not lock and medicines trolleys were unable to be secured to the wall. However when we returned to inspect against the warning notice issued on 20 December 2013, we found that medicines were securely stored on ward 20.

### Cleanliness

We saw that the hospital was in general clean and that the cleaners worked well with staff to remedy any issues. Policies and guidance was in place to meet the national guidelines in relation to infection prevention and control.

### Learning from incidents

Before we inspected Good Hope Hospital, we reviewed the large amount of information we held or the trust had sent to us. This information highlighted that there were three never events at Good Hope hospital. These are events that never should happen, although compared nationally, the trust is not an outlier in this respect.

We reviewed the mechanisms for collecting information on incidents and accidents and 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, and we saw the World Health Organization checklist in place in the theatre department.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

Many services across the hospital were providing effective care. However, we saw a lack of risk assessment in the A&E department that could affect patients' care. At our inspection on 27 February 2014, we found that risk assessments were currently in place within the A&E department at Good Hope Hospital. The ward staff knew the pressures on the trust and were aware of the actions taken by it and them in order to resolve these. Training was provided by the trust for staff but ward areas found it difficult to release staff due to the pressures on the ward. This meant that care was not as effective, as staff were not always up to date with their training requirements. An example of this was the lack of uptake on training in dementia care, resulting in staff not fully understanding the needs of patients.

## Our findings

### Evidence-based treatment

In the A&E department, we found during our inspection of November 2013 that there were no risk assessments undertaken to address the issues that patients were experiencing. Patients waiting for long periods of time were not provided with the care they needed. There were no care rounds during which staff could check that patients were comfortable, undertake observations and ensure that a patient's condition had not deteriorated. Fluid and food charts were not completed, despite staff assessing that they required these.

At our inspection on 27 February 2014 we found that these issues had been addressed. The clinical decisions unit was not being used for its original purpose: patients who were supposed to wait there for a short time were in fact waiting

up to four days for a bed in the ward area. At our inspection on 27 February 2014 we found that the criteria for admission to the clinical decisions unit had been reviewed and most of the time this was adhered to.

### Training

Staff told us that training was provided but that at times it was difficult to attend because of pressures in the ward areas. We were unable to see the percentages of staff trained in specific issues by hospital site because as information was not collected in this manner by the trust. We were able to see that the trust monitored the number of staff trained

On the medical wards, we found that there were significant numbers of patients with dementia. However, it was variable as to how many staff on a ward had had training in dementia care, although this was an objective for the trust. Most of the medical wards we visited did not have a dementia champion. This is important as a lead person can supply support and information when staff are caring for people with dementia. On our unannounced visit, we saw a number of people with dementia across four wards. On one of these wards, two people with dementia had fallen that day. We spoke to staff and found that people who showed confusion would have their bed moved overnight to a corridor near the nursing station so that staff could keep a close eye on them. We spoke to security guards who told us that they were often called when patients with dementia became aggressive. They told us that they had had no training in dementia and had learnt how to deal with people with dementia during the course of their work. This did not ensure effective treatment for people with dementia.

### Working with others

We saw some excellent examples of multidisciplinary working in the ward areas across the hospital. All staff within the ward teams felt valued and able to contribute to the care of patients.

# Are services caring?

## Summary of findings

Most people we spoke to were positive about their care. Much of the care we observed during the inspection was good. However, in November 2013 we had concerns about the A&E department, the medical and the paediatric wards where care was not always as person-centred as it might have been because of shortages of staff and the pressure staff were under.

Patients were full of praise for staff, although expectations about the level of care were low. The staff themselves wanted to provide a good level of care and often made extra effort to ensure that a particular patient had a good experience. This was very evident on the maternity unit where staff often stayed late to ensure that women had a positive experience of the delivery process.

The Friends and Family test however, introduced by the Government this year, shows that the trust is significantly below the national average indicating that people using the hospital would not recommend it to others.

At our inspection on 27 February 2014 we found that intentional rounding had been introduced to the A&E department and patients could be assured that their basic care needs were now being met.

wards were: Birmingham Heartlands Hospital wards 3, 9 and 12, at Good Hope Hospital ward 8 and at Solihull Hospital ward 15. We visited all of these wards during our inspection. While we saw some issues on these wards at Birmingham Heartlands and Solihull Hospitals we were not concerned by the care given at these locations. We received a number of concerns about the care from staff on ward 8 at Good Hope Hospital from patients and their families. We saw that in general the care provided was good during our inspection. We were concerned at the care of dementia patients, through the practice of their beds being moved into the corridors overnight, in ward 8 and that this was replicated in other wards in the hospital.

### 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. Patients also told us that they expected to wait for care. With regard to the A&E department, it was often said by patients that “you expect to wait for hours to be seen as the department is so busy”. One patient said, “You don’t go to A&E with a minor problem because you know that you will have to wait.” The information we hold about the trust showed us that the trust was regularly not meeting their four hour target from admission to treatment. However once seen the trust has a lower than the national average rate of readmission to the hospital within seven days of the initial assessment. This indicates that patients receive appropriate treatment on the first visit to the hospital.

### Observation

While most patients said that they felt cared for, in November 2013 we did find some patients in the A&E department who were clearly distressed but were not reassured by nursing staff. We also witnessed one example of this in the outpatients department. We saw some privacy and dignity issues as we inspected the hospital: curtains that were not fully closed, and patients being cared for in corridors overnight or on trolleys in the centre of A&E. At our follow up inspection on 27 February 2014 we found that due to the implementation of intentional rounding care for patients had improved.

## 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. In the A&E survey response rates are falling and the scores are well below the national average. This means that people are unlikely to recommend the unit to their family and friends as a place to attend.

Five wards were identified by patients as ‘extremely unlikely’ to be recommended to friends and family. These

# Are services responsive to people's needs?

(for example, to feedback?)

## Summary of findings

We found that the hospital was not always responsive to meeting the needs of its patients. Although we did see some good aspects of care for example we saw family and friends tests throughout the hospital and in general there was a sign that said, "You said – We did" telling patients and relatives what changes had been made. We also saw that the numbers of staff expected to be on duty were advertised in the ward area so that people could see the numbers of staff available for care and we saw some good practice in respect of children's and maternity services where the staff made an extra effort to ensure that people received a good service at the hospital. However in November 2013 this was outweighed by the delays patients were experiencing in A&E.

At our inspection on 27 February 2014 we found that patients were being seen quicker by a clinical member of the A&E team.

## Our findings

### Access

Good Hope Hospital 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. However the trust is not currently meeting the targets set in respect of A&E waiting times or in part the targets set for admission once a decision to treat has been made.

### Treatment of vulnerable patients

Staff were not responsive to the needs of people with confusion and dementia, often leaving relatives to deal with the fears and anxieties of these patients. We found that there was little responsiveness to patients with mental health issues. The room designated as a mental health room was used to store items of equipment and staff in the A&E department said they had had little training in dealing with mental health issues. Security staff were used to assist

staff in the restraint of people with mental health issues, despite their having had no training in this area. We also found this to be an issue within the paediatric and medical services at Good Hope Hospital.

Other units were responsive to the needs of patients. We saw that a falls coordinator had been appointed to advise on the prevention of falls in older patients. This was seen as having a positive effect by the staff on the wards. We saw that the bereavement services were responsive to the needs of the patients and the local community. While this was not such an issue here compared with at Birmingham Heartlands Hospital, we saw that there was effective use and knowledge of how to obtain translators at the hospital.

### Discharge planning

Before we inspected Good Hope Hospital, we reviewed the large amount of information we held or the trust had sent to us. This information highlighted that there were concerns regarding the bed occupancy level in critical care (93%), which was above the national average of 83%. Our inspectors reviewed this data and spoke to staff and patients. They found that staff were aware of the issue and that a critical care outreach team had been put in place to address this. This ensured that patients awaiting a bed in the critical care units were looked after effectively by staff who were supported to provide critical care.

Staff were able to talk about the challenges that the hospital faced. The greatest of these was the pressure on the A&E department. Staff spoke of the need to ensure that procedures for patient care (known as pathways) were followed and that timely discharge of patients took place 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. However, we saw that some patients were moved to inappropriate wards to free beds for new patients. This resulted in a number of issues for patients and staff, including delays in patients going to theatre and inappropriately experienced staff caring for patients.

We found that within the A&E department patients were waiting in excess of four hours for treatment. The hospital had failed to meet this target on a regular basis for a number of months. Staff struggled to get everyone seen within the four-hour target but, because of the volume of patients, this was not always possible. Staff were aware of the escalation procedure when the department was busy

# Are services responsive to people's needs?

(for example, to feedback?)

and the systems in place to try to find beds for people who were to be admitted; however, although these were in

place, they were not seen to be working effectively when we visited the department in November 2013. When we returned in February 2014 we found that staff were effectively utilising the escalation procedures.



# Are services well-led?

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

## Summary of findings

The senior management team at the trust was relatively new, but displayed an understanding of the issues that the hospital faces. The team was currently facing further changes because the chief nurse was in an acting-up position and the medical director was about to leave. This presented challenges of stability of leadership throughout the trust. However, the decision to treat each hospital as its own directorate was welcomed by staff, because they felt ownership of their hospital and its services. This was nowhere more obvious than at Good Hope, where staff felt that they worked for Good Hope Hospital rather than the Heart of England NHS Foundation Trust. Staff felt that their immediate line managers were supportive but that the senior management team did not visit the hospital often enough.

## Our findings

### Leadership and vision

Most departments felt that their line managers on the ward areas were supportive of them and the service they provided. We received three whistleblowing reports that said that senior staff were not visible within the hospital and that there was a perceived disconnect between staff in

the ward areas and the senior management staff. We could only find examples of this in the maternity unit where staff said that senior leaders were not visible or supportive. In every other department, we were told that the local management team was very supportive. In maternity, the staff reported that senior management were interested solely in the systems and processes, and not in supporting staff to provide a good level of care. Some staff in this area felt that they were working in a culture where mistakes were feared and not used as learning opportunities. In some areas of medicine, we heard that senior management did not value the concerns raised by staff and adopted a bullish approach.

### Management of risk





Staff welcomed the introduction of the supervisory status of the ward manager. They felt that this gave them an extra level of support. We were also able to see the impact of the amount of information available to the general ward staff about how well an area was performing. While not every metrics board was up to date, staff were aware of how well they were performing and were proud of their achievements.

### Cohesion

In some areas such as maternity and A&E we saw that nursing and medical staff worked very well together and were supportive of each other. We also saw examples of where physiotherapist, occupational therapists and others worked well with the medical and nursing teams.



# Accident and emergency

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

## Information about the service

The accident and emergency (A&E) department had 17 major and five minor cubicles, five resuscitation trolleys (including four cubicles for children, which are ring-fenced). There were a further five beds situated in a Clinical Decisions Unit (CDU).

Last year the adult emergency department saw in excess of 65,150 patients. The paediatric emergency department was responsible for seeing and treating approximately 13,523 children during the previous year.

The department is staffed by three consultants who are present on the shop floor for 16 out of 24 hours. After midnight there is one middle grade and two junior doctors on site, with the consultant on call from home.

## Summary of findings

The A&E department at Good Hope Hospital was very busy during our inspection in 2013. People who walked into the department were not being assessed by trained staff and this was a risk to their health and safety. There were delays in meeting the four-hour treatment targets as set by the Department of Health. This meant that patients were waiting longer than expected to receive treatment.

We spoke to patients and they accepted the fact that if they attended A&E they would have to wait for a long time. Patients found the department's staff caring. However, we saw episodes when people's privacy and dignity were not respected and care was delayed because of shortages of staff within the department. The trust had an ongoing recruitment programme and the effect of this had yet to be felt in this department.

At our inspection on 27 February 2014 we found that the process for assessing patients had been reviewed and this resulted in an assessment of their need by a clinical person within the recommended 20 minutes. We also found that care needs were being met by staff whilst they waited for treatment.

# Accident and emergency

## Are accident and emergency services safe?

Requires improvement 

### Risk assessment

In November 2013, we looked at care and treatment records for patients in the A&E department. We saw that, in most cases, risk assessments had not been completed. Venous thromboembolism (VTE) risk assessments were blank. VTE risk assessment is used to reduce the risk of deep vein thrombosis and pulmonary embolism for patients admitted to hospital. Some patients had the A&E frailty risk assessment completed. This was a predictor rather than an assessment of risk. It needed the staff member to implement care rounds when the score was four or above. We could not see any evidence of care rounds being carried out when a patient had a score of four or above. Patients were delayed in the department for many hours and needed risk assessment and risk management plans.

At our follow up inspection on 27 February 2014 we found that risk assessments were in place within two hours of the patient being seen and that the system of intentional rounding had been implemented. This system is designed to ensure that patients basic care needs are met on a regular basis.

There was a five-bed area within the A&E department known as the 'clinical decisions unit'. In November 2013 we were told that patients should not remain in the clinical decisions unit for more than 24 hours. One patient we spoke to had been delayed in the A&E department for a long time and was waiting in the clinical decisions unit for a medical bed to become available. Twenty-six hours after arriving at the A&E department, the VTE assessment had not been completed. The risk assessment for manual handling had not been completed. The patient had an existing pressure sore and leg ulcers. There was no wound chart in place. Staff had completed an appropriate pressure ulcer risk assessment and an appropriate pressure-relieving mattress had been provided. Another patient, who was waiting in the clinical decisions unit for a test, wanted to lie down but there was no bed available.

At our inspection on 27 February 2014 we found that the criteria for admission to this unit had been reviewed and that patients were in general not kept here for more than 24 hours. However should a move to an appropriate ward be delayed this was escalated to senior staff. We found at this inspection that some patients remained on the unit for longer than 24 hours.

### Staffing

The department is staffed by 11 qualified nurses and two healthcare assistants until midnight. Between midnight and the early shift commencing, there are eight qualified nurses on duty and one healthcare assistant. Two advanced clinical practitioners were employed to work in the department. These practitioners assisted with the treatment and assessment of patients. We saw that staff were extremely busy during our visit. Patients also told us this was the case. Staff told us that they often did not get cover for last-minute sickness or staff shortages. However, the department had recently recruited a number of nurses and staff felt that staffing levels would improve once these new nurses had started work.

At our visit in February we found that the department was still using a number of agency staff and that this impacted upon the admission and care patients received in the clinical decisions unit. We reviewed the patient risk assessment booklet and found that in two instances this had not been completed. Staff told us that this was because the agency nurse on duty was not familiar with the process.

### Equipment and environment

There was a separate five bedded bay known as 'resus', which was used for patients who needed close observation or resuscitation. There was one paediatric bed in the resus area. We saw that the resus beds were all occupied by adults. Not all patients in the resus area needed to be there. They were in resus because the department was full and there was no other available space. Resus beds should be protected so that they are available in the case of an emergency.

In November 2013, we looked at the equipment in the 'resus' area and saw the required equipment was in place. We looked at the resuscitation trolley in the minor injuries department. We saw that staff were required to check this trolley every day. We looked at records for the past three months and saw that the defibrillator had not

# Accident and emergency

been checked every day. However at our inspection in February we saw that this had improved and equipment had been checked daily. An audit system was in place to ensure that staff were undertaking this checking.

## Learning from incidents

We asked staff about reporting incidents and accidents. They told us they used an online reporting system. Most staff told us they always reported accidents and incidents. Some told us they were too busy to complete the reports. They felt that the process was pointless because nothing ever changed as a result of their reporting.

At our inspection in February 2014 we heard from staff that they now had time to report incidents.

## Escalation policies

Our inspection of 11 to 15 November 2013 we found that patients who walked into the department (rather than arriving by ambulance) were being 'streamed' when they arrived by non-clinical reception staff. This is accepted practice but patients should then be assessed by a healthcare professional within 15 minutes. We found that patients were not always being assessed within 15 minute and at times were waiting much longer.

Streaming is the process of allocation of patients to areas of the department. For example, a patient with a minor injury would be sent to the 'minors' area. A patient with a more serious condition would be sent to 'majors'. We found that there was a lack of clarity amongst reception staff about the streaming process. The reception staff were making decisions based on their experience rather than using a set criteria. Reception staff were not always asking appropriate questions about the patient's condition. In the 'majors' area of A&E we found that when the department became busy and patients were waiting in the corridor there were also delays in the assessment process and a lack of clarity amongst staff about who was responsible for looking after these patients.

We looked at patients' records and saw that at least four patients had not had their physiological observations checked or been assessed within an hour. Two patients did not have their physiological observations checked nor were they assessed for more than two hours from arrival. We saw that A&E was full during our visit. Patients brought in by ambulance were waiting in the corridor on trolleys. We spoke to the relative of one patient who said

that the patient had been waiting in the corridor for 1 hour 20 minutes. They told us that none of the A&E staff had assessed the patient or spoken to them, and that they did not seem to be aware that they were there. The patient commented that their bottom was becoming sore. Another patient waiting on a trolley in the corridor was waiting more than two hours. They had not been assessed nor had any physiological observations checked.

In February 2014 we spoke with the reception staff about the process of 'streaming'. They told us that all reception staff had received training about the streaming process and about the criteria to use. We saw that flow charts based on the clinical emergency medicine algorithms were being used to determine where to send the patient depending on their condition. Some changes had been made to the flow chart. There was a list of 'presentations' that required immediate nurse or clinical assessment. Staff were instructed to send all children attending the department to the children's A&E within 15 minute of arrival. Elderly patients who attended because of a fall were directed to the 'majors' area.

We spoke with nursing staff about the action that had been taken and time to assessment. They told us that in the majority of cases patients would be assessed by a trained nurse or clinician within 15 minutes of arrival. They also told us that if patients were not assessed within 15 minutes they would report this as an incident. Patients did not always present with symptoms that were typically associated with their condition. Therefore reception staff may not be alerted to the seriousness of their condition because this would not be listed in the flow charts being used.

## Are accident and emergency services effective?

(for example, treatment is effective)

## Clinical audit

Good Hope participates in several national audits relating to their A&E. They are currently now performing well in the College of Emergency Medicine fractured neck of femur. The trust continues to make progress in achieving the nine indicators and therefore improving outcomes for patients with hip fracture during the financial year 2012/13.

# Accident and emergency

We saw that, when patients were frail or elderly and delayed in A&E for a long time, they were given hospital beds instead of trolleys. We asked staff to explain the trigger point for giving a hospital bed. We were told that clinical judgement was used to decide this.

## Working with others

In November 2013, we followed two patients who had been delayed in A&E before being moved to the medical assessment ward. We saw that staff transferring the patients from A&E and accepting them onto the medical ward had not signed the transfer sheet. There were no nutrition assessments completed. The VTE assessments were also not completed. One patient had scored six in their early warning score (a method of assessing if patients require early treatment) while in A&E. A score of six should trigger escalation but we could not see any evidence of this. Another patient's early warning score had not been calculated. Fluid balance charts were not kept up to date and did not provide an accurate record of a patient's fluid balance. Many of the records we looked at were not signed, dated or timed.

We spoke to staff about food and hydration. They told us that sandwiches and hot drinks were available. However, there was no ward host or housekeeper employed. Healthcare assistants had to go to the wards to find sandwiches. Patients we spoke to confirmed that they had been given a sandwich and a hot drink. Patients in the clinical decisions unit were given a hot meal option. However at our inspection in February 2014 we found that intentional rounding had been introduced which included ensuring that patients were offered food and fluids to meet their needs.

## Are accident and emergency services caring?

Requires improvement 

## 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

We spoke to patients and relatives. Most told us that staff treated them with respect and dignity, and were helpful and kind. Some people told us they had not seen any staff because they were too busy. Many of the staff we spoke to were concerned that patients were cared for as A&E patients even when they had been delayed in the department or in the clinical decisions unit for several hours. Staff felt they did not have the time to respond to and look at the wider issues when the department was full.

In November 2013 we found that comfort or intentional rounding (this is when staff regularly assess the basic needs of patients) was not carried out. We were told that this would happen if patients were in the department for a long time. The staff were too busy to do it at the time of our inspection. We visited the A&E department at Good Hope Hospital on two occasions and could not find any evidence of such rounds being carried out. However, at our inspection in February 2014 we found that this was now in place and working well. Patients reported that they felt that this improved their wait in the department.

## Observation

In November 2013, staff were busy and overwhelmed by the pressures the department was under. This led to them presenting as not caring. Staff did not appear to have ownership of a patient's care and the only interactions with patients was of a medical nature. The department had become, in the main, task orientated. However on our follow up inspection we found that although the staff were still busy systems such as intentional rounding had had an impact on the care provided to patients in the department.

# Accident and emergency

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

Requires improvement 

## Access

The Department of Health's national target for A&E is that 95% of people should be seen and treated within four hours. We were shown weekly reports for the four weeks before our visit regarding patients waiting for more than four hours in A&E. Records showed that there were in excess of 100 patients delayed each week trust wide. We were told that the day before our visit there had been 51 breaches to the four-hour wait and that the average delay during our visit was more than seven hours.

In November 2013, we asked staff about the action they took when patients were in the department for longer than four hours. They told us that, when the department was busy and patients were nursed in the corridors, they informed the senior nurse on duty as site lead. Bed meetings were held at least three times a day to review the flow within the department and to identify available beds within the hospital. The trust sent us a flow chart of actions staff were required to follow in response to internal triggers in the department. For example, if patients were waiting more than two hours or there was a high volume of patients, then key members of staff had to be informed and take action. During our visit, we could not see evidence of this escalation response being followed. Staff told us that breaches to the four-hour wait and a full department occurred often.

At the time of our visit in February 2014 the A&E department was not very busy. There were no patients waiting on trolleys in the corridor. We spoke with staff about this. They told us that patients waiting on trollies continued to be a frequent occurrence on the department. Between the hours of 10 am and 10 pm when rapid assessment was being used the triage nurse who was part of the rapid assessment team was responsible for these patients. The provider may like to note that staff told us that when there was only one triage

nurse in the rapid assessment team it was difficult to also properly manage the patients in the corridor. We spoke with the hospital management team about this and they said they would look at ways to improve this.

In the majors area a system known as 'rapid assessment' had been introduced. This meant patients brought into 'majors' were immediately assessed by a team consisting of medical and nursing staff. Although there were continual and ongoing breaches to the four hour wait in A&E, this process meant that patients were seen and assessed very quickly even when the department was busy. The rapid assessment system was being used between the hours of 10 am and 10 pm when the department was at its busiest. We spoke with staff about the impact of rapid assessment. Staff were extremely positive and told us it had made a significant and positive difference. Patients were seen quickly and decisions about their care and treatment were made at the earliest opportunity.

## Treatment of vulnerable patients

Staff we spoke to were not aware of any specialist person within the hospital to provide advice and guidance to staff caring for people with dementia or a learning disability. They told us that, if necessary, they could ask a member of staff to give a patient one-to-one care. We saw there was a sign in the department asking people to give feedback about their experience in the department. There was no reference to the NHS friends and family test. The aim of this test is to improve patient care by asking patients whether they would recommend the hospital to friends or family if they needed similar care or treatment. Delivering this test became a contractual agreement in April 2013.

A psychiatric team was available to see patients with mental health needs. The team was available day and night. There was an appropriate room available where patients with mental health needs could be seen in private. The room had two exits and did not contain ligature points (points on which a noose could be hung). However, the room was also being used to store chairs and equipment. We spoke to staff about how they managed patients who were at risk to themselves or others. They told us that security staff and CCTV equipment were available. They said they completed a risk assessment for suicide risk when this was required.



# Accident and emergency

Security staff were available in the department when required. Staff had access to a panic button so that the security staff could be summoned quickly. We were told that patients who had been aggressive to staff in the past had a 'marker' on their records so that staff were made aware. None of the staff we spoke to had received training about conflict resolution or de-escalation techniques. Some had no understanding, or very limited understanding, of the Mental Capacity Act and associated Deprivation of Liberty Safeguards.

Staff we spoke to knew how to access the trust's safeguarding specialist for advice and guidance. We asked staff to describe the action they would take in the event of suspected abuse. They knew the correct procedures to follow, when to raise concerns and whom to report them to. This included making referrals to outside agencies such as the local authority safeguarding team when this was needed.

There was a separate paediatric area that was staffed with registered sick children's nurses during daytime hours. Staff had received training in safeguarding. Systems were in place to identify and alert staff if a child was known to social services or had a higher than normal attendance record. All children attending the department had their records reviewed from a safeguarding perspective and appropriate referrals were made.

## Discharge planning

Staff told us that, because there were no beds available in the hospital during our visit in November 2013, the A&E department was operating from three cubicles. All other available space had been taken up with patients waiting for beds. On our unannounced visit on the evening of Saturday, 23 November 2013, we found that the department was not busy. However, when we spoke to patients in the 'majors' area of the department, they had been seen by A&E staff quickly on arrival but were waiting significantly long periods of time for treatment. At our visit in February 2014 patients were seen quickly and decisions about their treatment were made at the earliest opportunity.

**Are accident and emergency services well-led?**

Requires improvement 

## Leadership and vision

We spoke to staff about the leadership and management team. One member of staff, in November 2013, told us that junior nurses were often in tears and very stressed when the department was busy. Most staff said that they felt supported by the local team however busy they were. Senior nurses and consultants worked as part of the team within the department undertaking clinical duties. This meant that there was little time to manage the department. We asked a member of staff who was in charge on that shift and they could not tell us.

At our unannounced visit we asked for the senior person on duty and after some discussion about who this was we were pointed to the team leader for that shift. There was a lack of nursing leadership and role modelling within the department. Nurses were overwhelmed by the tasks they had to do and did not have time to provide care for patients. At our visit in February 2014 we found that there was a significant change in the culture of the department. Staff were more focused and were aware of how to escalate issues to the senior management team.

Staff meetings took place every month for band 7 staff. Meetings were not regularly held for other grades of staff. Some staff, in November 2013, told us they had never attended a team meeting.

## Management of risk

Staff said they did not receive feedback about incidents or accidents they had reported. Changes were communicated to staff during shift handovers and by email, but staff did not always get time to read emails. There was no evidence of any quality monitoring or audit in the department when we asked staff for this.

## Cohesion

In November 2013, they told us that when the department was busy the matron and other senior managers came to help them. At our inspection in February 2014 we found that senior nurses from across the hospital had been seconded into the A&E department to ensure that they had an appreciation of the challenges the department dealt with.








## Accident and emergency

All the staff in A&E worked as a team and supported each other. We were told that the medical and nursing staff worked well together. A staff nurse said that there was a strong consultant presence in the department and

consultants were always there when it was busy. Most staff we spoke to told us they felt supported by their line manager. They had received the training they needed and development opportunities were available.

# Medical care (including older people's care)

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

## Information about the service

Good Hope Hospital provided medical care in a number of wards that offered general and specialist medical care to patients. These included wards for people who had had a stroke, people with respiratory illnesses and older people.

We made both announced and unannounced visits as part of our inspection of these wards. We visited the acute medical unit, often the first ward for patients admitted via A&E, and nine other medical wards. We visited wards for older people, people with respiratory disease, wards for cardiology and acute medicine, and the stroke unit.

On 27 February 2014, we returned to ward 20 to monitor compliance against the warning notice issued in December 2014. We found that this area was compliant with the warning notice.

## Summary of findings

Staff were able to give examples of when they had learnt lessons from complaints or serious incidents, and they saw this as positive. We found that patients were happy with the care that they had received from staff although they acknowledged that they might have to wait for care because staff were busy. The numbers of staff on duty were routinely published at the end of the wards and staffing levels seen during our visit were safe. However we spoke to a number of staff who had been moved from their regular ward to another who did not feel that they had the skills or experience to adequately care for patients on their new ward. At our unannounced visit we went to three wards where dementia patients were being cared for. We found that on each ward the way that night staff managed these patients over night was by moving their beds into the corridor area. While this may reduce the risk of patients falling from their beds it does not enhance their privacy and dignity.

In November 2013, we saw that the acute medical unit (Ward 20) had been reopened to prevent the use of the day surgical unit as an outlier area for patients with medical conditions. However, this unit was found not to be staffed or resourced, and in some areas, such as patient equipment, staffing, medicines management and confidentiality of records, it was unsafe. We spoke to the senior management team at the time of our inspection and saw that action was taken to address some of the issues. We were sent daily bed reports informing us of the number of staff on duty for a week



# Medical care (including older people's care)

following our visit to this ward. However this daily review did not include aspects of safety such as ensuring that staff had the experience required to care for the patients on the ward.

When we returned for our unannounced inspection, we found that the action taken had not been sustained and that there was little permanent staff allocated to the ward, the medicines storage remained unsafe and patients were not being cared for by staff who had the appropriate skills, knowledge and experience.

At our inspection on 27 February 2014 we found that the issues we had raised had been addressed.

## Are medical care services safe?

Good 

### Risk assessment

Staff used a tool for measuring the risk of patients developing pressure ulcers. The trust had a system to check whether this tool was being used. This information was usually available on notice boards on the ward. Some wards displayed this information very effectively. Staff told us that they could access special equipment to prevent pressure ulcers. We saw records that showed that in most cases patients' risks were accurately assessed and appropriate action taken.

The trust had a high rate of falls per thousand bed days. This was being addressed in a number of ways. Falls had been identified as a priority for 2012/13 and was to remain as one for 2013/14. The trust also had a Commissioning for Quality and Innovation (CQUIN) target for falls reduction.

There was one falls coordinator for the whole trust. This person provided support to all the trust's sites as well as providing a twice-weekly clinic at Birmingham Heartlands Hospital for referrals from the community.

- The falls coordinator provided support to reduce falls in the following ways:
- Half-hour training on each staff induction course.
- Falls reporting and monitoring via the IT system.
- Teaching and presentations.
- Reviewing every incident form involving a fall.
- Promotions: 'Call don't fall', 'Leave it low before you go'.

Falls were monitored via Datix reporting and the metrics system. The falls coordinator provided information to show that, while the trust's rate of falls per thousand bed days was above the national average, falls were decreasing at all three sites.

### Staffing

Staff told us that staffing levels dropped when there was sickness. However, the trust was currently recruiting staff and had improved the process to reduce the time between recruitment and start date for successful staff. Senior sisters on most wards said that they had been recruiting staff who were due to start shortly once recruitment checks were completed. This was confirmed at interview with senior staff from the Human Resources department. Staff told us

# Medical care (including older people's care)

that recruitment procedures had been improved so that pre-recruitment checks were completed more quickly and therefore vacancies were filled sooner. During our inspection, we saw that there were sufficient staff on the wards we visited. Staff reported that staffing had increased very recently. Most of the wards we visited displayed on a board how many staff should be working on each shift on the ward, so that patients, staff and visitors could see. The wards we visited were staffed to these numbers.

Staff reported that they were often moved between wards when there were shortages of staff, and there was high usage of bank and agency staff. This meant that there was a risk of lack of continuity of care for patients and that patients were being cared for by staff who may not have the skills and experience to care for their needs.

## Equipment and environment

Checks of resuscitation equipment were taking place so that staff could be confident that emergency equipment was available and in good working order should it be needed.

## Medicine management

Medicines were stored securely.

## Cleanliness

When we visited wards we saw that they were clean. Hand gel was available at the end of every patient's bed. We saw staff using good hand hygiene and wearing protective equipment such as aprons, gloves and masks when necessary. Policies and procedures were in place to prevent and control the spread of infection.

## Learning from incidents

We saw that patients' needs were well assessed and risk assessments were normally completed and updated as necessary. There was intentional rounding carried out to ensure patients' needs were being met. We found evidence that wards learned from incidents. Staff at Birmingham Heartlands Hospital had identified a problem in the respiratory ward and come up with a solution to prevent recurrence. This had been shared with the ward at Good Hope Hospital that cared for patients with similar needs. However, we could not find evidence that lessons were consistently shared across specialities and sites to improve practice. Staff we spoke to were hopeful that the introduction of the supervisory Band 7 senior sisters would help embed the practice of learning lessons from incidents and complaints.

The ability of the hospital to remain safe and have effective systems in place for reporting and learning from incidents depended on adequate and consistent staffing levels being maintained.

## Ward 20/AMU

In November 2013, all the wards we visited at Good Hope Hospital felt calm and ordered except Ward 20, the acute medical unit. When we arrived on the ward, the door was open and no staff were on the desk. There was a friends and family test box containing comments; however, these were not from the current ward, which had opened seven days prior to our visit. . There were three qualified nurses (one bank and one moved from Ward 11) and two healthcare assistants (one agency and one from Ward 10) working. The senior nurse was a charge nurse from A&E who told us that he had worked a bank shift on Monday on the ward and had been asked to work on the ward on the day of our visit. He told us that there was no ward manager. There were 14 patients when we arrived. The ward had 18 beds.

There was an emergency trolley that had not been checked for six days. On this check, it had been identified that there was no A4 mask or spare roll for the ECG. A nurse checked the trolley and found a mask and spare roll. There was no sharps bin, however and this meant that while all the equipment was now present there was no facility for making any used items safe.

We spoke to the matron for the area who explained that the ward had been open since Wednesday, 6 November, and there were currently no establishment staff. The staff we spoke to told us that they had an induction to the ward. The staff on duty had a handover about the patients on arrival. Staff had been able to identify which patients were at risk of falls or pressure ulcers.

We then checked the ward to see whether patients had all the equipment they needed. There were two patients without lockers. One patient's belongings were in a hospital plastic bag on the floor behind their chair. The patient in Bed 12 had no easy chair to sit in. Unoccupied beds also had no lockers and there was no bed for the space marked Bed 17.

There was also no clock for patients to check the time, which is necessary to orientate patients. Medicines were not stored safely. There was a keypad on the door to the clean utility room. We saw that the number of this keypad

## Medical care (including older people's care)

was on the whiteboard in the office so all staff could gain access. This had been done because of the changes in staff on the ward and to ensure that staff would be able to access the room. In the store room there were two drug trolleys, one in use. These were not secured to the wall as required and there was no way to do this. There were medicines in cupboards that were not secure. They had been locked but, because they had not been latched shut, the locks were ineffective and they could be pulled open. The fridge was not locked and contained medicines. We asked staff to lock the fridge: they were unable to do so because there was no key. There were three bags of medicines left on the cupboard. The drug trolley was very full with bags of patients' own medicines in it. Staff told us that there was a door missing from the controlled drug cupboard and that this was being mended; in the meantime, staff had to access controlled drugs from another ward. We spoke to senior management about the arrangements for the secure storage of medicines and were informed that these would be rectified immediately. However, on our unannounced visit on the evening of Saturday, 23 November 2013, we found that the medicine cupboards were still not latched properly, rendering the locks ineffective; and although the fridge was signed as not to be used, with alternative refrigerators on other wards to be used instead, we saw a number of insulin products stored in the fridge. On this visit, we also saw a number of pharmacy products in unsealed containers, awaiting return to the pharmacy department.

We found a complete set of medical and nursing notes left unattended on the unmanned desk at the entrance to the ward. We later saw that a notes trolley had been acquired for the unit. We saw that this was still in use on our unannounced visit.

At our inspection on 27 February 2014 we found that records showed that checks on emergency equipment were completed daily. The trolley was very well organised. The senior sister told us that the trolley had been checked the day before our visit by the clinical governance lead who had identified that the size 4 mask was not labelled. We saw that action had been taken to address this and that the trolley now had a labelled size 4 mask.

The clinic room was very well organised and tidy. Medicines were stored securely in cupboards and the medicines fridge. There were completed forms for staff to sign at every shift change to show that storage of medicines and

controlled drugs had been checked. Senior staff told us that medicines to be returned to pharmacy were now stored in locked cupboards and this system had been rolled out throughout the division.

There were regular audits taking place on the ward which showed improvements since December. The audits included checks on medication storage and the emergency trolley where the ward scored 100% in February. We saw that where the audits had identified improvements were required, such as ensuring patients were weighed, these were communicated via a board in the staff office and via email.

We found that the hospital had taken action and that there were effective systems in place to identify risks and action was taken to address them. Since December there had been a permanent staff team in place, led by a senior sister and two sisters. There was a ward clerk and a housekeeper. The staffing rotas confirmed this.

The ward was full and was calm and very well organised. All patients had lockers to store their belongings and chairs to sit in (this had not been the case during our November inspection). We spoke with two patients on the ward who were very happy with the care they were receiving from all staff including nurses, doctors and the ward housekeeper.

We spoke with staff on the ward who all said that the ward was much more organised than when it had first opened. All the staff we spoke with said that there was a strong team culture and that they all wanted to make patient care excellent and that patient care was their main priority. Staff told us that there was good consultant cover and junior doctors said they were well supported. The patients we spoke with said they had seen their consultant and knew what was happening with their care and treatment and felt that the doctors kept them well informed. One patient said: "They're very, very good doctors and nurses."

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

Requires improvement 

### Evidence-based treatment

According to the Stroke Improvement National Audit Programme (SINAP) Good Hope was performing in line with

# Medical care (including older people's care)

national averages. As it does not provide primary angioplasty (this is offered at the Heartlands site), it does not contribute to the Myocardial Ischaemia National Audit Project (MINAP).

## Training

Mandatory training figures provided by the trust showed that there was some variation across medical care. Staff told us that because of staffing levels they were not always able to access training. The trust was now providing some training online, although some staff were unhappy that protected time was not available for training. The recruitment of more nursing staff and supervisory ward managers should also improve access to formal training and ad hoc training on wards. There was a lack of clarity at ward level and in the information provided by the trust about the number of staff who had received training in dementia care. We found only one ward that had a dementia champion. Development training had been provided for staff in supervisory roles.

The trust had a training plan for dementia that was part of its dementia care CQUIN target. Training was provided in a variety of ways including drop-in sessions and training days. The trust had a plan to improve dementia care. It aimed to have 5% of staff as dementia champions and 70% of staff as dementia aware. Hardly any of the wards we visited had a dementia champion. There were variations across the wards in how many staff had dementia training. The training figures provided by the trust were not broken down into sites or specialities so we were not able to see clearly how many staff working on medical wards had received dementia training. Staff told us that they could not always attend training because of staffing levels. One of the physiotherapists at the focus group identified at their performance development review meeting that they wanted to be a dementia champion, and they had plans to become one. During our unannounced visit on the evening of Saturday 23 November we went to three wards where we found patients with dementia being nursed in the corridor in case they fell from their beds. While this reduced the risk of falling it did mean that people's privacy, dignity and care was being compromised.

## Working with others

Staff we spoke to at the physiotherapist and occupational therapist focus group were able to tell us the trust's values. They told us that the hospital was a good place to work and many staff had worked at the trust for their entire career.

However, the physiotherapists told us that they had moved to recording care electronically about two years ago. Other disciplines were going to move to electronic recording but currently paper records remained. This meant that records for patients were kept separately, and there was a risk of important information not being shared that could have an impact on patient care.

We found some evidence of good cross-departmental working with good cross-site working by cardiologists and in oncology. However, there were many differences between wards and, overall, the hospitals seemed to operate separately. Staff knew how to access support when a patient's first language was not English. The hospital kept a list of staff with language skills and staff contacted the switchboard.

Mental health support was available via the RAID team and we saw evidence that, when referrals for mental health assessments were needed, these were made and carried out in a timely manner.

## Clinical audit

There was evidence that the systems for sharing information from incidents and complaints was not consistently embedded across all staff and areas. Most wards displayed information on their performance against metrics.

## Are medical care services caring?

Requires improvement 

## 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 be recommended to friends and family. At Good Hope Hospital ward 8 was identified in this group we also received a number of concerns about the care from staff on ward 8 at Good Hope Hospital from patients and their families. When we visited this ward during our inspection, we saw that in general the care provided was good. We were concerned however at the care of dementia patients,

# Medical care (including older people's care)

through the practice of their beds being moved into the corridors overnight, in ward 8 and that this was replicated in three other wards in the hospital. Patients were moved into the corridors so that the nursing staff could keep an eye on patients while they continued to work as there were not enough staff available to support the person in the main ward area. This meant that patients privacy and dignity was not being respected and individualised care was not promoted.

## Patient-centred care

Patients we spoke to said that doctors and nurses had discussed their care and treatment with them in a way they understood. They also told us that staff kept them informed and that they felt listened to. Staff we spoke to also understood the importance of involving patients in decisions about their care and treatment. The hospital used a 'red jug' system to identify patients who needed support with eating and drinking. When patients were identified as needing support, we saw that there was a red jug lid in place. We saw that staff recorded how much patients had eaten and drunk when this was needed.

## Observation

All the patients we spoke to said that they were happy with the care they had received. We also observed staff providing good levels of care. We saw staff take their time to listen to patients and answer their questions, even when the ward was busy. Patients used words such as 'brilliant' to describe the care they had received. The wards, although busy, were very calm. Nobody raised any concerns about the care that they or their families had received.

## Are medical care services responsive to people's needs?

(for example, to feedback?)

Requires improvement 

## Access

Information on patient experience was gathered as part of the metrics to evaluate care as a whole. There were friends and family test boxes outside all the wards we visited but mostly there was no information on what patients had fed back or what the ward had done in response. Some of the

boxes were empty of cards for patients to comment on. Many of the patients we spoke to were not aware of how to make a complaint. However, we saw that there were signs on the wards that told people how they could do this.

## Treatment of vulnerable patients

The hospital served a diverse population with many non-native English speakers, but information was only available in English. One of the steps of the falls care pathway was for the patient and/or relative to be given a falls leaflet. This was only available in English. There were effective systems in place to access translators; however, we saw no evidence that information was available in any language other than English. The cultural mix of the staff reflected the community that they were providing care for and so the use of translators was minimal.

## Discharge planning

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.

Because of the pressures on beds in the trust, the hospital had taken steps to improve patient flow. There were external pressures that also had an impact on the hospital's ability to discharge medically fit patients; these included the availability of beds in care homes and intermediate care services. The trust had implemented a number of ways in which discharges were monitored. These included the following, setting targets for wards to encourage discharges early in the day, using electronic boards (JONAH boards) for handover and identifying patients ready for discharge, and holding frequent bed management meetings throughout the day. The acute medical service had also been redesigned to increase capacity. We observed JONAH board handovers and saw that these worked well.

We were told by several staff that medical patients had often been cared for on the day surgery unit. Agency staff and staff borrowed from other wards would then be brought in to cover the unit overnight. We were told that there were criteria for the patients who would be looked after there and that they would require little care and be nearly ready for discharge. We requested the criteria but



## Medical care (including older people's care)

this information was not provided and there was no system in place to check that the criteria were being adhered to in times of pressure for beds. This was essential so that the situation could be monitored and ensure that people were cared for in an appropriate environment. During the month of October 2013, there was an average of 28 surgical beds occupied by medical patients. This meant that patients were at risk of delay in treatment and surgical patients might have their operations cancelled because beds were filled with patients from medical specialities. Staff told us that they could usually access the appropriate doctors easily but that they were trying to improve the patient flow to ensure that patients were cared for on the correct ward and to reduce unnecessary moves between wards for patients.

Patients waited for discharge in the lounges they were being discharged from. Some staff felt that this was increasing pressure on the staff because they had to look after the full ward and then monitor the discharged patients waiting in the lounge.

### Complaints / whistleblowing

The hospital had responded to an anonymous email from a staff member. It was dealt with under the trust's whistleblowing policy and an inquiry undertaken. The

inquiry was very wide ranging and made recommendations that sought to address the issues uncovered. For example, a band 5 competency development plan for acute medicine was developed. One finding in the inquiry was that there was a lack of consistent senior operational or nursing leadership.





### Are medical care services well-led?

Requires improvement 

#### Leadership and vision

It was noticeable that a large number of staff referred to Birmingham Heartlands Hospital as the 'mother ship'. Staff reported that they felt that the CEO was more visible at Heartlands than at Good Hope. When staff had moved across sites, they had more knowledge and understanding of opportunities across the sites but these systems were not completely embedded. Nursing staff we spoke to were very positive about the introduction of supervisory status for senior sisters. Staff also told us that matrons and senior nurses were visible and available to support them. Medical staff also mentioned improved leadership. Staff told us that they felt supported and able to raise concerns.

# Surgery

|            |                                                                                          |
|------------|------------------------------------------------------------------------------------------|
| Safe       | Good  |
| Effective  | Good  |
| Caring     | Good  |
| Responsive | Good  |
| Well-led   | Good  |

## Information about the service

Good Hope Hospital provided surgical care and treatment to its local population. There were six wards delivering surgical treatments across a variety of specialities. We visited all these wards and talked to staff, patients, two visitors and two visiting social workers. We looked at the pre-op assessment unit and the day surgery unit. We also visited the theatres.

We spoke to patients, medical and nursing staff, and ancillary staff.

## Summary of findings

Patients felt that the hospital provided safe surgical services. However, a visitor noted that not all medical staff used the hand sanitisers when entering the ward area. We saw examples of where staff were learning the lessons from incidents. We found that documentation was kept up to date and that patients were encouraged to return to normal as soon as possible after their operation.

Patients told us that they were treated with dignity and respect when in hospital and a system of protective meal times ensured that people were able to eat without interruption. On the day surgery unit, we were informed that medical patients had previously been admitted, which had had a detrimental effect on some surgical patients.

# Surgery

## Are surgery services safe?

Good 

### Staffing

There were sufficient numbers of staff in the ward areas when we visited them as part of our inspection. We checked staffing rota's and saw that in general the number of staff planned to be on duty were maintained despite sickness and other absence.

### Equipment and environment

We received positive feedback from patients we spoke to who felt it was a safe hospital. We saw good practice in the prevention and care of patients with pressure ulcers, including appropriate risk assessments, care plans and use of equipment. Nursing staff confirmed that patients with a pressure ulcer had access to specialist advice about tissue viability if needed.

One of the wards (Ward 16) was cluttered because of a lack of storage facilities that meant equipment was stored in corridors, creating a trip hazard. Some fire doors were propped open with cardboard boxes and the fire assembly point was not indicated on the fire evacuation instructions by the fire door.

### Cleanliness

We saw that there were appropriate infection control systems, but we were told by a visitor that they were not strictly observed in all areas. For example, they told us that, while waiting for the ward to open for visiting, they observed seven medical staff enter the ward but only one of them used sanitizing gel on their hands.

### Learning from incidents

We discussed never events with a consultant surgeon and the theatre manager. They explained how they implemented the World Health Organization checklist, which is used to ensure safe surgery to reduce the risk of never events. The theatre nurse manager told us they used both a paper copy and an online copy (via an iPad) and that these were regularly audited. The never events that had happened at the hospital were on display in the theatre area, to ensure staff were reminded to use the safe surgery checklist at all times.

## (for example, treatment is effective)

Good 

### Evidence-based treatment

We looked at a number of patient records across the surgical wards. We found that patients' medical histories and treatment plans were documented in their medical notes. Nurses recorded patients' progress in the relevant section in the nursing folder. We saw that records were clear and legible.

Staff confirmed that patients were encouraged to walk independently to aid their recovery. We asked if falls risk assessments had been completed and were told they formed part of the care plan known as the 'enhanced recovery pathway'. However, the nurse was unable to find anyone on this pathway and there were no specific risk assessments completed for those people at risk of falls following their surgery.

## Are surgery services caring?

Good 

### Patient-centred care

The hospital operated a protected meal times policy. We were told that clinical staff were discouraged from visiting the wards at this time. Patients and their relatives told us that they were treated with dignity and respect.

### Observation

We saw, and patients told us, that staff treated patients with kindness and compassion. Patients also told us that they were pleased with the care they had received and that they were happy with the way staff had treated them.

## Are surgery services effective?



# Surgery

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

Good 

### 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.

Staff told us that medical patients were being treated on the surgical wards. This was because there were not enough beds on the medical wards. For example, there were 11 medical patients on one of the wards that should have had 28 surgical patients. Risk to patients increased if they were not admitted to an appropriate ward or were moved between wards as staff do not always have the appropriate skills and experience to care for patients' needs. There were single-sex bays and single side rooms to ensure privacy and dignity for patients. Privacy screens were used by staff when appropriate.

### Treatment of vulnerable patients

We were told that there was a dementia lead nurse for the surgical area as well as a learning disability lead nurse based at the trust to provide support across the three hospital sites. A number of staff told us they had received recent training on dementia awareness, delivered by the dementia lead nurse. A staff member also told us the 'butterfly scheme' had been implemented on the ward, so that patients with dementia could be identified easily.

Staff spoken to were able to discuss safeguarding procedures and knew how to escalate any concerns they might have. They confirmed they had training in safeguarding and said it was mandatory.

### Discharge planning

We found that the hospital responded to the increased demand for emergency treatment by admitting medical patients due for discharge to the day care surgical unit. This meant that the beds on medical wards were used for emergency admission. However, this did not always

happen in a planned or coordinated manner. For example, staff told us that there had been occasions when the day surgery unit had been opened overnight to accommodate medical patients who were shortly due to be discharged. Day surgery staff had to care for these patients as well as admitting the patients due for day surgery. Staff told us that they did not always have the specialist skills to support patients' medical needs and nurses told us they sometimes had difficulty locating medical teams to review the medical patients and arrange discharges. Some patients stayed on this unit as inpatients for up to four days. This meant that planned surgery was sometimes cancelled.

The hospital had a patient discharge policy that set out the level of support a patient would be given when they moved either back into their own homes or into a care facility. We saw a community discharge nurse assessing a patient who was being discharged that day. The patient told us that the arrangements had been made for support to be available to them when they went home. They said they felt confident that this would help them recover quickly and regain their independence.

### Complaints

We saw that each ward had a process called 'You said – We did', which enabled patients and their families to make suggestions and comments and receive feedback on what the trust had changed and/or improved. This procedure was prominently displayed on all wards. We were told that this was a new initiative and staff were not able to give us any examples of changes made as a result of any comments received.

## Are surgery services well-led?

Good 

### Leadership and vision

Staff we spoke to on the surgical and day wards told us that they felt well-supported and that their wards were well-led. Senior staff told us that matrons were visible and supportive.






# Surgery

## Management of risk

The management team in theatres had taken a number of steps to minimise the likelihood of never events. It had developed a defined safety culture in theatres. Patient safety checklists had been implemented in all theatres, and these were now an integral part of theatre practice.

Safety and quality of care were monitored and action taken in response to concerns. Ward managers on two wards told us they monitored their performance against department standards. Staff were informed of the outcome of quality monitoring to improve performance. For example, there were infection control audits of hand washing as well as audits of incidences of falls and pressure sores.

## Intensive/critical care

|            |                                                                                          |
|------------|------------------------------------------------------------------------------------------|
| Safe       | Good  |
| Effective  | Good  |
| Caring     | Good  |
| Responsive | Good  |
| Well-led   | Good  |

### Information about the service

Good Hope Hospital had eight operating theatres in its main suite, and two theatres in the day surgery unit. The critical care unit had 10 beds. We spoke to 19 medical and nine nursing staff working in the critical care unit, as well as two relatives and two patients.

### Summary of findings

We found that services within the critical care area were safe. Staffing was at the level required by national guidance and staff were found to be caring and compassionate. Communication flows of information from other areas of the hospital were good and lessons learnt shared with all staff. The support of the critical care outreach team was valued by other staff in the hospital; however, bed capacity in this unit was sufficient for the hospital's needs.

# Intensive/critical care

## Are intensive/critical services safe?

Good 

### Staffing

Staff confirmed that staffing arrangements were safe. One trained nurse provided care for each person who was assessed to be level 3 and one nurse provided care for up to two people who were level 2 patients in accordance with national guidelines for critical care. The nurse in charge told us about a drawback of having all single rooms, and as a result patients were normally supported on a one-to-one basis.

### Equipment and environment

The critical care unit was new and purpose built. All beds were in side wards and the unit was spacious. Occupancy was much less than at Birmingham Heartlands Hospital. This unit had capacity and staff confirmed that it was usually underutilised. The unit had an additional six beds, which had not been commissioned but could be used in emergency situations.

### Learning from incidents

Staff told us that 'lessons learnt' throughout the hospital were included on the hospital intranet. The nurse in charge told us that 'near misses' were also printed off and included in the handover folder for discussion at handover. Staff confirmed that there was follow-up to critical incidents.

## Are intensive/critical services effective? (for example, treatment is effective)

Good 

### Evidence-based treatment

According to the Intensive Care National Audit and Research Centre (ICNARC) data, Good Hope's critical care unit performs within expectations.

There was a coordinated and embedded critical care outreach service that operated 24 hours a day 7 days a week with staff at each of the three hospitals within the trust. The critical care outreach team was aware of trends and issues and gave us examples of actions undertaken to address these. The critical care outreach team checked

people who had recently been discharged from the intensive care or high dependency units, provided advice and support to wards, and also provided care and support to people who were being cared for outside critical care and may be waiting for an intensive or critical care bed. Information supplied by the clinical care outreach team identified that the trust did not always meet the standard of admission to critical care within four hours, with a peak in March and April 2013 when 11 and 18 patients respectively were managed outside critical care for more than four hours. We found that critical care arrangements at the present time were safe.

### Training

Staff reported that there had been a large number of experienced staff who had left because of proposed changes in working arrangements. This had resulted in new and inexperienced critical care staff being recruited. Staff all received a six-week induction in critical care nursing. All nurses then undertook introductory modular training that included critical care competencies in which they had to be assessed as competent before they could complete their induction. After at least 18 months' experience, they then undertook advanced modular training in critical care nursing. After that they could apply for a critical care nursing qualification. We were told that only nurses who had an additional critical care qualification could apply for band 6 positions. At the time of our inspection, more than 56% of nurses had this qualification (this met critical care core standards of at least 50% of nurses with this qualification). Staff told us that they felt supported to undertake training to develop their practice and the department's practice.

### Working with others

The unit was spacious and capacity generally above requirements. The majority of core standards for critical care were found to be met. We looked at patient records showing patients had a recorded and multidisciplinary plan of care that was reviewed by the medical staff at least twice daily. Nursing care observations and checks were undertaken at least hourly. Records we looked at confirmed that people received the care and treatment they needed. We spoke to staff who confirmed that the critical care unit had effective multidisciplinary working within the organisation.

## Are intensive/critical services caring?

# Intensive/critical care

Good 

## Patient-centred care

We observed all staff to be kind and caring. Staff we spoke to were caring and highly motivated to provide good care to their patients and support for their family. Records showed that loved ones were kept informed of care and treatment needs and, when bad news was discussed, it was done so compassionately and sensitively.

## Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Good 

## Access

Bed capacity for this critical care unit (intensive care and high dependency were combined) was not an issue and patients received timely care within the correct environment of the critical care department. Six-monthly coffee mornings were arranged for all ex-patients and relatives to discuss their experiences of the unit and the care provided.

There was a strong and responsive critical care outreach team throughout the hospital and the trust. Staff told us that they supported colleagues on the wards with seriously ill patients and records we saw confirmed this.

## Are intensive/critical services well-led?

Good 

## Leadership and vision

We were told that proposed changes to working practices, which required nurses to work in both Good Hope and

Birmingham Heartlands hospitals, had been poorly managed and as a result several staff had left. Staff said that this had led to a decline in morale, although this had recently begun to stabilise. Staff reported good team working and a supportive senior member of staff within the unit. However, they said that they did not feel supported by management because of the loss of a matron for the department and the current practice of one matron working across the two hospital sites. This matron told us that there had been additional demands on capacity so she had been based solely in Heartlands critical care unit and that a nurse consultant was present on the Good Hope Hospital site two days a week. There was some lack of clarity of roles in the absence of the matron. Staff reported that meetings were rarely held although the senior nurse said that they tried to keep staff updated individually when they saw them.

Staff told us that they had a mentor group and all confirmed that they had an annual appraisal and the training they needed. They also had an excellent induction and this induction was tailored according to their previous employment and experience.






## Management of risk

To ensure effective use of staff and their skills, the department had a system to 'star' names on the off duty rota. This identified that there may be need for them to work at the Heartlands site and reminded them to ring in before their duty to check this. Staff agreed that this gave flexibility and ensured that they could be responsive to patients' needs – staff in the right place at the right time.

## Cohesion

Discussions with staff confirmed that the critical care outreach team was well-led and provided appropriate support. However critical care outreach staff told us that they struggled with the demands of the service and would be late going off shift at least 50% of the time.

# Maternity and family planning

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

## Information about the service

Maternity services were provided from all three hospitals with women able to choose where they had their babies. Women were also able to access maternity-led services and water birth facilities. Good Hope Hospital had had nearly 4,000 live births in the previous year.

## Summary of findings

We found that there was an increased demand in staffing required at Good Hope Hospital to meet the requirements of staff obstetric theatres. We also found that, while the requirement for translation services was less than at Birmingham Heartlands Hospital, there was inconsistent use of interpreting services.

Overall, we found that there was poor visibility and communication from the senior leaders in this directorate. Staff felt that they were managed from afar (Heartlands Hospital) and that management was aggressive. There was good support provided by the modern matron at this unit. Some midwives reported poor consultant presence on the delivery suite; however, there was good team work and peer support. Specialist midwives were available to support vulnerable women within the community. We saw good clinical effectiveness – in particular, the use of research and evidence-based policies and procedures.

# Maternity and family planning

## Are maternity and family planning services safe?

Requires improvement 

### Staffing

The head of midwifery confirmed that the birth ratio was above the national guidance of 1 midwife to 28 women, but explained that work was under way to address the shortfall in midwives. The modern matron also explained that there was a large number of midwives on maternity leave, which had increased the birth ratio to 1:40. This is far above the national standard of 1:32 deliveries. We spoke to senior management who explained that they had recruited more than 16 band 5 (junior) midwives, and a further 11 staff were awaiting the recruitment checks to be completed before beginning employment. This impacted on patient care as midwives were managing up to 40 women at any one point. This is exceptionally busy and unsafe.

Staff in the delivery suite explained that the theatres were not always covered by theatre staff and so midwifery staff were used to staff the theatres. One midwife said, “We can be taken away from caring for women in labour to undertake the role of a scrub nurse in theatre. It is frustrating and does not give continuity of care to women.” We saw that staffing in obstetric theatres was the top risk on the risk register and that it was discussed by the clinical risk and audit committee. However, it was unclear to us what plans were in place to address the shortfall as this was not described on the risk register and staff could not tell us about the plans.

There was a consultant presence on the delivery suite and staff told us there were plans in place to increase consultant cover from 59 hours a week to 68 hours. However, there was a sense among the staff that cover was better at Birmingham Heartlands Hospital. The Future Role of the Consultant guidance produced by the Royal College of Obstetricians and Gynaecologists recommends for units delivering up to 4,000 births there should be 60 hours of consultant time and for units between 4,000 and 5,000 there should be 98 hours of consultant time spent in the delivery suite. Doctors in training told us the consultants covered both obstetrics and gynaecology and were therefore not always available on the delivery suite.

We noted that there was a project under way to explore the options available to overcome the capacity concerns. Staff were engaged in the process and described to us the possible solutions. This showed that the board had acknowledged the capacity demand and had taken steps to rectify the issues. Staff added that, because of the capacity concerns at Birmingham Heartland Hospital, 90% of intrauterine transfers went outside the catchment area. However on review we noted that only 44% of intrauterine transfers went out of the immediate catchment area. One midwife had travelled to The Wirral the week previous to our visit as babies under 34 weeks’ gestation were not delivered at Good Hope Hospital.

Most staff were working long shifts without breaks and there was a reliance on bank staff to cover gaps within the rotas. We also spoke to midwifery support workers who told us their work was often task orientated, rather than being able to give holistic support to women and midwives.

We asked for and received the staffing hours worked on the bank during October 2013. Our specialist adviser analysed the data and identified that at least seven members of non-bank staff were exceeding the European Working Time Directive by working more than 60 hours a week. We saw and heard that women were cared for; however, this was only achieved by staff working over and above the standard for working hours.

### 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 extensive audit programme. The findings and learning from this process were escalated through the service and to the board. We asked staff to explain how learning from incidents and complaints was cascaded to all staff. Their response was mixed. Some of the staff were able to explain changes to practice because of learning from incidents. We saw newsletters and alerts that included learning from incidents. However, a number of staff said these were communicated through the email system. They did not always have access to emails and told us communication at times was poor. We saw results from



# Maternity and family planning

audits and patient experience were displayed on whiteboards in the wards and departments, making the information very visible to staff and people using the service.

## Are maternity and family planning services effective?

(for example, treatment is effective)

Good



### Evidence-based treatment

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

### 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. . Staff had little understanding of what subjects were needed for mandatory training. However, when questioned, most staff were unclear what mandatory training should be attended.

We spoke to maternity support workers who said they were well supported in their role by the project midwife. The project midwife told us their focus was on the continued development and training of support workers. The ward clerks had recently won an award for improving care. The clerks had worked together to look at different ways of working to improve patients' experience. The trust had recognised their innovative ways of working.

### 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 cascaded to all staff. The trust undertook a variety of daily, weekly, monthly, quarterly, six-monthly and annual audits. The results were clearly displayed in every ward and department. Staff, and people who used the service, were able to see on a monthly basis whether they were improving or not.

## Are maternity and family planning services caring?

Good



### Patient-centred care

The women we spoke to told us they were happy with their care. One woman said, "The care here is second to none. The staff looked after me as much as the baby. I was shown great respect and privacy and had my own room."

We saw that most women and their families were involved in their care. Most said they felt their partners were involved in their care and that they were able to complete their care and birth plans with the support of a midwife. Some women told us they were well cared for but at times would have appreciated more information. For example, one woman said, "I had a scan last week and was asked to come back for a repeat scan. We were not given much information as to the reason why." We spoke to the woman following her repeat scan and she told us she was now much more informed and understood the reasoning behind her planned care.

### Observation

We saw evidence that two-hourly comfort rounds were undertaken. Staff explained that these rounds were to ensure women were comfortable and their needs were being met. A modern matron told us that staff dealt with any requirements but had an escalation process should they be unable to fulfil a particular need. We walked around the location and saw that doors and curtains were closed and people knocked on doors before entering. This showed us that people's privacy and dignity were respected.

## Are maternity and family planning services responsive to people's needs?



# Maternity and family planning

(for example, to feedback?)

Requires improvement 

## Access

At times there were not enough staff to maintain all the services. Staff told us that, at busy times, they were asked to limit the use of the low risk and water birth rooms. This meant that women may not be able to have the type of birth that they had planned. One member of staff also said, “The option of epidural pain relief in labour has on at least one occasion been limited to reduce the need for one-to-one care in labour.”

## 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, staff were inconsistent in their responses. A few staff explained how they used the language line; others felt that it did not maintain people’s privacy, especially in the reception area. Other staff were not aware of all the services available to aid communication.

We did, however, find some evidence to demonstrate that interpreters were used. Staff showed us that people had access to interpreters, which enabled them to communicate their needs to staff. We saw during our visit that staff had used interpreters and family members to communicate; however, the use of interpreters was inconsistent.

The provider 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. This showed that the provider based care around the needs of the population.

## Discharge planning

The demand for the maternity service had increased and staff told us that at times they were overworked and stretched. They explained that there were delays in the flow of patients through the service. These delays were caused by excessive documentation, duplication of paperwork, breakdown of IT systems and longer neonatal pathways.

## Complaints

We saw evidence that the family and friends test was carried out and the results displayed in the ward areas for staff and people using the service to view. We saw comment books available for people to write in and the complaint process was available for 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. We heard that the staff felt that the management was only interested in systems and processes rather than the support of the workforce. One member of staff said, “There is a real sense of being managed from afar and the management at Birmingham Heartlands Hospital can come over as aggressive and bullying.”

Staff told us they felt supported by the modern matron and we saw a very good modern matron presence in all the areas we visited. 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 on call throughout the day and night. The ratio of supervisors to midwives was slightly higher than the recommended national standard of 1:15 at 1:14. The midwifery support workers were supported by the project midwife and the newly qualified midwives by a perceptorship midwife.

## Quality monitoring

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 findings and learning to staff, we were repeatedly told staff did not understand the trends, learning and changes to practice.








## Maternity and family planning

We saw a risk register that was populated and reported through to the clinical risk and audit committee and on through the trust governance structure to the board. The top three risks were staffing levels, staffing in obstetric theatres and length of stay. The management was reactive

to risk and staff told us consultant cover was being increased and midwifery staffing was being addressed. However, from what we saw and heard, there was still a sense that staff felt unsupported by senior management.

# Services for children & young people

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

## Information about the service

Good Hope Hospital offered a children and adolescent inpatient and outpatient service for patients between the ages of 0 and 16 years. Following a review of children's inpatient services at Good Hope in January 2013 because of concerns with regard to the availability of qualified children's nurses and as a result moving all junior doctors to Birmingham Heartlands Hospital at the request of the deanery the inpatient service was closed. This was replaced with the children's assessment unit, which opened in March 2013. This unit consisted of four assessment beds and four observation beds with a capacity of eight observation beds during winter. The maximum stay on the unit was 23 hours. If the length of stay was anticipated to be longer than 23 hours, a transfer pathway was developed for the patient to be transferred to the inpatient ward at Birmingham Heartlands Hospital.

The paediatric outpatients department held a variety of clinics. During the year 2012/13, there were 4,800 attendances at this department. There was a dedicated area for children within the A&E department. This was staffed mostly by registered children's nurses and was closed at midnight and re-opened in the morning at 7am.

The hospital had a level 1 neonatal unit.

## Summary of findings

None of the parents or patients raised any concerns with us about safety at the hospital. Children's safeguarding procedures were robust and were improved in response to findings from a serious case review. Assessments were done of patients' needs on admission by both nursing and medical staff, and care and treatment were delivered effectively. Parents spoken to were mostly pleased with the care and treatment that the hospital had provided, and positive about the staff.

There was a lack of appropriate response to the management of children with mental health needs and a lack of an effective response to the shortage of permanent senior paediatric doctors (registrar, middle grade), which had an overall impact on the delivery of care. At times there was a shortage of nursing staff with the appropriate skills, knowledge and experience to care for patients. A lack of clarity on the function of the redesigned inpatient service meant that pathways in place were not always followed and the service was not responding to the needs of patients who were admitted.

There was a strong management presence in the form of the head of nursing, matron and supervisory ward sisters. We saw evidence of regular senior meetings and completion of audits to monitor the quality of service provided. There was evidence of learning and improving as a result of incidents that had occurred. Arrangements were in place for the management of high-risk issues that affected the hospital. For example, the hospital had

# Services for children & young people

proactively responded to concerns about staff shortages and bed occupancy of the inpatient assessment unit. However staff felt that the focus was on the Heartlands site and that they were marginalised by this.

## Are services for children & young people safe?

Requires improvement 

### Staffing

There were two qualified children's nurses and a healthcare assistant on during the day and night shifts.

During weekdays and office hours, there was always a band 7 on duty (supervisory sister, previously known as ward manager) who held the paediatric bleep. Their role was the management of the ward and staff and to respond to any concerns such as staffing levels and occupancy. Out of hours there was a band 6 in charge who would hold the paediatric bleep and have responsibility for dealing with any issues across both Birmingham Heartlands Hospital and Good Hope Hospital.

Prior to our visit all junior doctors were relocated to Birmingham Heartlands Hospital by the deanery amid concerns about their training experience. The unit was temporarily closed but has been reopened by the trust as a 23 hour assessment unit. This means that children are seen and treated at Good Hope Hospital however if continued treatment is required children are transferred to Heartlands Hospital. The assessment unit is staffed by two children's nurses and a healthcare assistant. Medical cover is provided by two paediatric consultants covering between 8am and 16.30, a paediatric registrar and a junior doctor who covered the children's assessment unit, A&E and the neonatal unit. When the registrar was not on duty, shifts were covered by locum doctors. All patients were seen by the registrar before discharge. At times when a paediatric consultant is not available on site there is cover provided through an on call rota.

We saw that, on one occasion during the week, the registrar was involved in the transfer of a sick baby to Birmingham Heartlands Hospital. This meant there was no registrar present at Good Hope Hospital leaving only the consultant on call. This was unsafe as there was no paediatric doctor available on site should a child's condition deteriorate.

Staff at the children's assessment unit told us that, as well as admissions into the assessment and observation beds, there were regular ward attenders to the assessment unit for bloods and reviews, and this could have an impact on

# Services for children & young people

their workload. We saw, and some A&E staff told us, that sometimes patients were not being accepted into the children's assessment unit because staffing levels were not adequate. We saw written evidence of this on one occasion when staffing levels were the usual numbers but the assessment unit staff were not happy to accept a child or adolescent who needed mental health care onto the ward. Another example we saw was of a sick baby who attended Good Hope Hospital's A&E and was then transferred to the children's assessment unit before being transferred to Birmingham Heartlands Hospital paediatric high dependency unit the next day. The parents said they did not feel confident about their baby being in the children's assessment unit compared with the special care baby unit; they felt isolated and thought that their baby had not been monitored as well as they could have been. Other parents commented on how transferring their child or baby to Birmingham Heartlands Hospital was taking them a long way out of their local area.

There was also an issue with regard to surgical day cases being booked into the children's assessment unit instead of the day case ward at Birmingham Heartlands Hospital. The head of nursing told us that they were aware of this issue and addressing it. They told us that there was a pathway for transferring patients between Good Hope and Birmingham Heartlands hospitals, and that this was based on risk and the length of expected admission. However, we saw that this pathway was not always followed.

## Cleanliness

There was restricted access to paediatric services with intercom access for visitors. All the areas of the paediatric service were clean and tidy. There were wall-mounted alcohol rubs and hand wash basins at various points on the wards. Staff had access to protective personal equipment (gloves, aprons).

## Learning from incidents

The trust had put in place systems to learn from incidents. An example of this is the processes and support put in place following the serious case review described under responsiveness.

**Are services for children & young people effective?**

(for example, treatment is effective)

Good 

## Evidence-based treatment

Children who were admitted to the inpatient wards were risk assessed on admission and their care was planned accordingly. The paediatric early warning system was used across the wards to assess children's clinical observations and alert nurses to take action when scores were high. We saw evidence of integrated multiprofessional daily records and ward nurses attended medical handovers to ensure there was good communication between doctors and nurses about each child's care.

The documentation used in children's A&E departments prompted staff to ask questions about social history to establish any history of safeguarding. There was an alert on the electronic record system to flag any known concerns such as safeguarding or meticillin-resistant staphylococcus aureus (MRSA) infection. A Hospital at Home service (PATCH team) run by a team of experienced nurses to enable rapid discharge from hospital and to reduce unnecessary and prolonged admissions to hospital – for example, managing children with constipation at home, or children who needed intravenous antibiotics.

## Training

An electronic staff rostering system was in place and this helped to support effective planning of staff numbers and skill mix on any given shift. Staffing levels were based on the Royal College of Nursing guidance 2013 for general paediatric wards. The head of nursing told us that the rate for staff completing mandatory training was 93% and all staff confirmed that they had received mandatory training.

## Clinical audit

There was evidence of regular quality monitoring audits (nursing metrics) that looked at key areas – for example, infection prevention. An overall score of how the ward was performing was given, and this was on display on the ward notice board and visible to all. Any areas that required improvements were highlighted as 'The lesson of the month'.

**Are services for children & young people caring?**

# Services for children & young people

Good 

## Patient experience

We saw that there were friends and family test forms in all areas for parents and patients to give feedback on the quality of the service. The head of nursing said that the paediatric service had only gone live in the past month, so there was no analysis yet of the scores and response rates.

## Patient-centred care

The neonatal unit had a 'Welcome to the Neonatal Unit' booklet, which covered both Birmingham Heartlands and Good Hope hospitals and included a range of information for parents, covering, for example, what parents should bring for their baby, accommodation and visiting. A newborn baby pack was given to parents, which included information in leaflet and DVD format and details for BLISS (a charity that offers support for all premature and sick babies and their families). There was a separate children's service website with details of the services provided.

## Observation

In the children's assessment unit, there was a parents' lounge with facilities for parents to make themselves a hot drink. Parents had open access to the ward and were able to stay overnight with their child. The environment was well maintained and there were toys and activities available for children. Nearly all the parents told us that they were happy with the care and treatment that the hospital had provided. They told us that staff had listened to them, they had been kept informed and involved in their child's care, and that communication between them and the staff was good. One set of parents commented on the delay in being transferred from A&E to the children's assessment unit, and the lack of explanation.

**Are services for children & young people responsive to people's needs?**  
(for example, to feedback?)

Good 

## Treatment of vulnerable patients

Staff told us they were able to use interpreters when children and their families were not fluent in English but

they did not often contact them because most of the time families were able to communicate adequately in English. Two parents whom we spoke to, whose first language was not English, said they preferred to have family interpreting, and one said there were usually staff who spoke their language.

We identified that the trust was not responsive to child and adolescent mental health needs. We saw evidence that there were a large number of children who were admitted with a mental health admission across the Birmingham Heartlands and Good Hope hospitals. Over a six-month period, there were a total of 180 admissions; a number of these were repeated admissions for the same patient. Staff at both sites told us that caring for a child and adolescent with mental health issues patients could be challenging. Some staff referred to incidents when patients' behaviour became challenging as 'frightening'. We saw that there were no Child and Adolescence Mental Health Service (CAMHS) -specific trust protocol, policies or pathway in place.

We saw an example in the records of a patient admitted to Good Hope Hospital who was extremely vulnerable. This patient waited nearly four hours before being admitted to the children's assessment unit. Records showed that the paediatric registrar did not see reviewing the patient as a priority. Staff told us that they had not received any training on CAMHS/basic mental health/managing challenging behaviour. The head of nursing told us that training was being arranged via the CAMHS team. Staff confirmed that, if a patient required close monitoring 'Special', this would be done by a healthcare assistant because qualified staff would be unable to do it because of workload demands.

We saw in Good Hope Hospital that a generic trust risk assessment was used to risk assess a vulnerable patient. The risk assessment determined the level of observation they needed – for example, whether the patient required one-to-one. However, we saw that this risk assessment was not sufficiently detailed and it was not possible to assess on the basis of risk factors. There was no guidance for staff on how levels of risk were determined and no training was provided. We were told by staff that there were occasional incidents when security staff were called because of physical violence or aggression. Security staff confirmed this but said it was a rare event. Staff told us that only security staff were trained in restraint.



# Services for children & young people

Staff showed us that they knew about the different types of abuse and how to raise any concerns. All staff had received safeguarding training and told us that they were supported well by the safeguarding team based at the hospital. The safeguarding team provided safeguarding supervision for staff involved in ongoing safeguarding for patients on the ward, and we saw evidence in records of safeguarding supervision. The aim was to provide staff with support and guidance on the process to ensure good outcomes for patients.

There was a named paediatric consultant for safeguarding. The named doctor expressed general concerns about how children's services operated at high demand and their strategy for managing referrals that they felt put children and partner agencies at a disadvantage. The named doctor explained they had a weekly meeting on Fridays, 'Grand round', which included consultants from Good Hope Hospital and trainee doctors, when they discussed interesting cases to highlight key learning points. There was also a peer review system in place that allowed consultant paediatricians to discuss safeguarding concerns with the named doctor. They told us that all consultant paediatricians had received level 3 safeguarding training.

There was a protocol in place for staff to ring relevant health and social care professionals such as the GP, health visitor or school nurse when there were concerns about a patient. The safeguarding lead nurse told us how improvements in safeguarding procedures were made in response to the recent serious case review. This included better training for paediatric consultants and an alert system in A&E departments that would alert staff to information such as safeguarding concerns (we saw evidence of this on the electronic record system). A&E records included routine questions regarding whether the patient had a social worker, health visitor and common assessment framework in place. There was a section on the electronic discharge form that meant a doctor could not discharge a patient without providing information about safeguarding. There was a paediatric health visitor liaison service that looked at all children's A&E admissions and shared information with the health visiting team in the community. All staff had had safeguarding children's training because this was mandatory. Staff thought that they were becoming more probing with regard to safeguarding and able to escalate concerns appropriately. All the actions from the management review of the recent serious case review had been implemented.

## Are services for children & young people well-led?

Requires improvement 

### Leadership and vision

The head of nursing and matron covered both hospitals where children's services were provided. The head of nursing was at Good Hope Hospital once a week and the matron twice a week. There was no matron in post for neonates. There was a band 7 nurse in charge of the children's assessment unit. We did not meet that nurse on the day of our inspection because they were on training. Some of the staff told us that they had a supervisory role but that this had not yet been implemented in the children's assessment unit. The trust told us that this was implemented in all paediatric and neonatal units in October 2013. However these sisters are not on site at Good Hope hospital 5 days per week as they also take part in the paediatric senior nurse rota which is based at Birmingham Heartlands hospital. There were monthly senior nurse meetings that were facilitated by the matron. These involved reviewing how band 7 nurses were managing their wards, and assessing key performance indicators for band 7 nurses.

### Management of risk

Conversations with both the head of nursing and matron suggested that they had a good grasp of the issues facing the children's departments, and this was corroborated by what we saw in practice. For example, they were aware of the issue about CAMHS and this was evident in the 'Success, Learn and Change' poster (July 2013), as explained later in this section. However, some of their plans and protocols were prevented from being fully effective by issues at Good Hope Hospital because they had little control over, for example, the medical staff.

Arrangements were in place for the management of high-risk issues that affected the trust. For example, the trust had proactively responded to current concerns in relation to staff shortages and bed occupancy in the inpatient ward at Good Hope Hospital.

There were 'Success, Learn and Change' posters on the paediatric wards that were about paediatric quality and safety feedback; these provided staff with key themes coming from incidents over the past month. An example of



# Services for children & young people






this was in July 2013 when the poster referred to an increase in CAMHS patients and actions to be taken – that is, any transfers must be escalated to the on-call nurse to identify availability of beds, and all patients must receive daily risk assessments to help ascertain if specialist one-to-one care was needed from a registered mental health nurse. The aim was to give feedback to staff on incidents that had occurred, so that learning could take place.

## Cohesion

Staff felt that the service at Good Hope Hospital was seen as inferior to that at Birmingham Heartlands Hospital. Comments made included, “If we raise anything, we are told just to get on with it.

Staff we spoke to were positive about the care that they provided; however, they felt that the focus was on Birmingham Heartlands Hospital and that morale among staff in the children’s assessment unit was low. It appeared that the implementation of a 23-hour children’s assessment unit was not fully accepted at the Good Hope hospital site. There were some inconsistencies in what staff said about feedback from complaints and incidents; some staff said feedback was given and others said it was not.

## End of life care

|            |                                                                                          |
|------------|------------------------------------------------------------------------------------------|
| Safe       | Good  |
| Effective  | Good  |
| Caring     | Good  |
| Responsive | Good  |
| Well-led   | Good  |

### Information about the service

The palliative care team worked across the hospital sites and therefore Good Hope Hospital has a palliative care team led by a doctor. When appropriate, the team provided end of life care directly to patients throughout the trust, as well as supporting and training staff on the wards.

We spoke to 5 patients and 10 members of staff, including staff nurses, the lead nurse for end of life, the coordinator for end of life, end of life consultants, a social worker, bereavement service officers and ward sisters. We observed care and treatment and looked at four patient records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

### Summary of findings

Patients received safe end of life care. They had support to make decisions about their care and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patients and their families had positive views about the end of life service. The hospital had worked hard to meet the needs of its local ethnic population and to ensure that the religious and cultural needs of people at the end of their life were met in a timely and sensitive way.

# End of life care

## Are end of life care services safe?

Good 

### Staffing

Services at Good Hope Hospital were safe in respect of end of life care. The palliative care team was led by a palliative care consultant who was also the medical director at the local hospice. This ensured that there were good links with community-based services.

## Are end of life care services effective? (for example, treatment is effective)

Good 

### Evidence-based treatment

The Liverpool Care Pathway had now been withdrawn and the hospital was working with the National Council for Palliative Care to develop a new approach to care. However, the care teams continued to discuss the wishes of the person and their family in order to ensure that people's experience of death was as positive as possible.

### Training

Training was provided in end of life care, swallowing assessments, moving and handling, and staff were supported to undertake further study either through the local hospices or within the hospital. The trust had developed master classes in compassionate care, which included enabling staff to have the necessary difficult conversations with relatives and patients. The feedback from staff on this programme had been very positive. The hospital offered a range of qualifications in care at the end of life from certificate to master's level. It had a programme called 'Compassionate employers', through which it supported staff appropriately.

## Are end of life care services caring?

Good 

### Patient experience data

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

Care plans were checked daily to ensure that staff were providing appropriate care. People we spoke to said that the nursing team was very caring and always available to answer their questions. The project 'It's the little things', which reviewed the small things staff could do to make the death of a loved one a better experience had also been implemented at the Good Hope Hospital site. As a part of this project, a compassionate pack was made available to relatives who did not want to leave their loved one. This contained a few items such as juice, crisps, pen, paper, etc. in order that the relative did not have to leave the side of their loved one.

## Are end of life care services responsive to people's needs? (for example, to feedback?)

Good 

### Access to service

The Cancer Patient experience Survey (CPES) is designed to monitor national progress on cancer care. 155 acute hospital NHS trusts took part in the 2012/13 survey, which comprised of a number of questions across 13 different cancer groups. Of the 64 questions for which the trust had a sufficient number of survey respondents on which to base findings, Heart of England NHS Foundation Trust was rated by patients as within the top 20% for six questions and being in the bottom 20% of all trusts nationally for five of the 64 questions. The five questions rated highly by patients were around the information given to patients and care planning while those in the bottom five related to management of pain and explanation given by doctors.

### Treatment of vulnerable patients

The trust had worked with religious leaders in the local community to ensure that people dying at the hospital had as good an experience as possible. The hospital developed a DVD with the Muslim community and for staff going to the

# End of life care

coroner's court. The trust was doing well on meeting their CQUIN target in respect of the preferred place of death. It also ensured that bodies of Muslim patients were released to the family quickly, irrespective of the day of death.

## Discharge planning

The work that the trust had done with the religious leaders in the local community had had a positive impact on the timely release of the body to the family, and had ensured that hospital staff understood what a good death was for different religions.

The mortuary service had worked with funeral directors to ensure that they could accommodate everyone using their service. The bereavement midwives had just won the Butterfly award (which is a recognition from Mumsnet designed to raise awareness of the death of a baby) and had bereavement suites on both the Heartlands and Good Hope units that they supported. The medical examiner spoke to every relative about the death of their loved one, and explained the medical terminology on the death certificate. Four weeks after the death, contact was made to ensure that the family were coping and to offer advice about organisations that might be helpful for support.

## Are end of life care services well-led?

Good 

### Leadership and vision

The palliative care team was led by a specialised palliative care consultant and a dedicated team of palliative care nurses. Staff on all wards reported that they felt well supported by this team. The head nurse was also the head of bereavement services. This person championed the needs of the end of life service. She supported the successful palliative care business case for the expansion of the palliative care team to the trust board and worked with the medical examiner to ensure that every death was as positive an experience as possible.





### Management of risk

The medical examiner worked with his colleagues and reviewed every death. This ensured that lessons were learnt and that care could be improved. He worked with the junior doctors teaching them about end of life care.

### Cohesion

Nursing staff were encouraged to work with the local hospices in order to enhance their knowledge of good end of life care.

# Outpatients

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

## Information about the service

The outpatients department was located in one area within the trust. The access to outpatients was via the treatment centre. However, there was some confusion from patients about where the entrance was.

## Summary of findings

We found that the department was clean and well organised. The staff were passionate about delivering good quality care. Services were not always responsive to the needs of patients. We had a lay person with the inspection team who could not see. There were no signs in braille and no floor markers to tell blind people where they were. Items were placed along the walls, making it difficult for blind people to access areas. Letters that were requested via email for blind people were not always sent, and, when they telephoned, receptionists asked them for reference numbers, which of course they could not see.

# Outpatients

## Are outpatients services safe?

Good 

### Staffing

There were enough staff on duty at the time of our visit.

### Equipment and environment

We saw equipment was kept up to date and there were checking systems in place to make sure that equipment was kept in date and fit for use.

### Cleanliness

We spent time looking at the environment and could see that the premises was clean and hygienic. Patients had ample opportunity to clean their hands with antibacterial gel. There were lots of signs to encourage people to do this throughout the department.

## 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.

### 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

We spoke to volunteer guides, reception staff and nursing staff during our visit. Without exception, all the staff told us they were there for the patients and wanted to give them the best care they could. We spoke to patients who were

waiting to be seen in clinics. They told us, "The staff have been very good; they keep me notified when things are running a bit behind," and "I've been waiting a while to be seen but they have told me that things are a bit late; it's usual for here."

Staff told us, "We know when clinics are running late and we have a tannoy system so we can announce the delay and keep people informed." One staff member added, "We have delay in some appointments because one of our consultants is so popular the patients choose to wait so they can see him."

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

Good 

### Access

We were accompanied by an expert by experience during our inspection of this outpatient department. Our expert had no sight and found navigating the department especially difficult. We noted that there was a lack of signage; the entrance to the outpatient department had no visible indicator on the glass doors. We found that there were no signs provided in Braille; the signage that was available was suspended from the ceiling and difficult to read. In addition, another patient told us, "I wanted the main entrance but ended up here." A member of staff told us, "The sign above accident and emergency needs removing because that is the main entrance. People always find their way here. We are very good at signposting people now."

Information supplied for patients was available about specific medical conditions but, if you wanted this in a different language, staff told us they did not know how to get this. We were told by senior staff that this was available would need to be ordered.

We were given a specific example of where the trust could improve its communication for patients. We were told that an appointment letter was sent to a patient despite a specific request to have this information via email because the computer was set up to read the email. The patient was unable to read the letter and had repeatedly asked for the information to be sent by email. The trust consistently sent

# Outpatients

appointments through the post. This meant the person had to rely on other people to help them and have access to their personal information. We were told, “This is my information about my health. I would like to know what it is first, without relying upon a carer.”

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

## Complaints

We saw information displayed around the department for patients about the friends and family test, and how to make complaints known to the trust.

## Are outpatients services well-led?

Good 

### Leadership and vision

All the staff we spoke to said they felt fully supported by the management team.



# Good practice and areas for improvement

## Areas of good practice

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

- The work of the falls coordinator, who supported and trained staff throughout the hospital, was an area of good practice at Good Hope Hospital.
- The bereavement service also provided support to staff and family during a traumatic time. The 'It's the little things' project had shown some benefits to people, and those we spoke to who were recently bereaved felt supported by the trust.

## Areas in need of improvement

### Action the hospital **MUST** take to improve

- The initial assessment of patients for treatment provided in the A&E department.

- Patient flow throughout the hospital to enable the A&E department to function effectively
- Ensuring patients are cared for on appropriate wards and clinical areas, to ensure effective use of facilities.
- The safety of patients on the acute medical unit (Ward 20) by the creation of a ward team.
- The security of medications on the acute medical unit (Ward 20).

### Action the hospital **COULD** take to improve

- Reduction of the use of agency and bank staff by continuing recruitment of permanent staff.
- Training for staff working with children, adolescents and adults with mental health issues.

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 | <p>Regulation 9 HSCA 2008 (Regulated Activities)<br/>Regulations 2010 Care and welfare of patients.</p> <p>People who use services were not protected against the risks of receiving treatment that is inappropriate or unsafe as there was no timely assessment of the needs of the person using the service. Regulation 9 (1) (a) The planning and delivery of care did not always occur in the A&amp;E department to ensure that the patient's basic needs were attended to. Regulation 9 (1) (b)(i) (ii)</p> |

| Regulated activity                       | Regulation                                                                                                                                                                                                                                                                           |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Treatment of disease, disorder or injury | <p>Regulation 23 HSCA 2008 (Regulated Activities)<br/>Regulations 2010 Supporting staff.</p> <p>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).</p> |

| Regulated activity               | Regulation                                                                                                                                                                                                                                                                           |
|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maternity and midwifery services | <p>Regulation 23 HSCA 2008 (Regulated Activities)<br/>Regulations 2010 Supporting staff.</p> <p>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).</p> |

| Regulated activity | Regulation |
|--------------------|------------|
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This section is primarily information for the provider

## Compliance actions

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).

### 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).