

Heart of England NHS Foundation Trust

Quality Report

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

Ratings

Are services at this trust well-led?

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

The trust had undergone significant changes in senior and executive management due to the trust not meeting nationally identified targets. We used the intelligence we held about the trust to identify that we needed to undertake a responsive inspection of the all three acute sites (Birmingham Heartlands Hospital (BHH), Good Hope Hospital (GHH) and Solihull Hospital (SH)) Emergency department (ED), Medical care, Surgery, Critical care and Outpatients and diagnostic imaging (OPD D). In relation to Critical Care we inspected this service only at BHH as it had been rated good previously and wanted to see if it had improved further. We also inspected some community locations these included the Chest clinic, two dialysis units, Runcorn Road and Castle Vale, and community adult services.

The inspection took place with an unannounced inspection on 06 September 2016 and on that day we gave the trust short notice of our return on 18 to 21 October 2016. We had previously inspected the trust in December 2014; this was due to concerns relating to the trust's ability to meet national targets. We had also seen changes in the executive team which could have had the risk of unsettling the staff groups.

At that inspection we inspected the domains Safe, Responsive and Well-led. The core services visited during that inspection were ED, Medical care, Surgery (please note, we were not able to give surgery a rating due to an internal CQC issue) Maternity and Gynaecology and OPD DI at all three acute sites. We did not look at any other community services.

We did not inspect Maternity and Gynaecology, the trust had commissioned an independent review which was taking place at the same time. We thought it would be excessive to have two inspection teams putting undue pressure on the staff on the units. We also did not inspect Children and young people and end of life services.

We have not rated the trust overall as we did not inspect the exact same services and domains. We use this report to describe the ratings each core service has achieved and how that compares to the previous inspection.

Please note we have given the Well-led section of the report a rating as we had sufficient information to do so at an overall level.

ED overall rating was; BHH was requires improvement which was better than the inadequate from the 2014 inspection. SH was rated as good which was an improvement from requires improvement that it was rated as in 2014. GHH was requires improvement which was the same as the previous inspection.

Medical Care overall ratings were; good at both BHH and SH; this was an improvement on the previous inspection.

BHH remained the same with a rating of requires improvement.

OPD DI saw both BHH and GHH increasing their ratings to good from requires improvement. SH remained the same with a good rating.

Surgery was rated as requires improvement at BHH and GHH, with good at SH.

Critical Care achieved a good rating at this inspection at BHH.

In addition to this we also inspected a number of community services. These had not been inspected in 2014 and we wanted to inspect these services. We found the following;

Chest Clinic , Runcorn Road Dialysis, Castle Vale Renal Unit and Community adult services were all rated good. This was the case for all domains, with the exception of Runcorn Road Dialysis well-led domain which achieved an outstanding rating.

SAFE

- Incident reporting and learning was open and transparent. There were systems in place disseminate learning trust wide.
- Executive root cause analysis meetings took place, where incidents were scrutinised in more detail and was attended by a member of the executive team.
- We noted the trust delivered the requirements of the Duty of candour and staff had a good understanding of their individual responsibilities.

Summary of findings

- The trust undertook regular infection audits, to identify staff compliance and areas for improvement. During the inspection we did see that some areas needed to improve IPC practice, notably at GHH, where theatre staff were seen outside of the theatre suite in scrubs.
- Safeguarding adults and children all levels met or exceeded the trust target.
- The trust undertook mortality and morbidity meetings, where lessons were identified and shared for learning.
- There were seven active mortality outlier alerts open September 2016. The trust was actively working on identifying the cause and learning.
- There was a staffing shortfall in nursing, medical and dental, non-clinical staff and allied health professionals. Bank, agency and locum use was high.

EFFECTIVE

- Evidence based clinical pathways were being used. Policies were written in line with best practice guidelines.
- Risk assessments were undertaken appropriately. We saw nutrition and hydration assessments, and where identified patients needing support were offered it. This was reinforced by a coloured tray system, as an at a glance process to identify patients needing support.
- The trust participated in 97% of national clinical audits.
- The trust did not have Joint Advisory Group (JAG) accreditation, at the time of the inspection. They were working with JAG to regain the accreditation.
- Multidisciplinary team working was well embedded, and we saw good outcomes for patients and staff as a result. For example, the community the Rapid Response Team working from the community hub brought together MDT to avoid hospital admissions and keep patients safe at home.

CARING

- We observed staff displayed a genuine interest in patients. We saw that dignity was maintained. However, we did see that due to space constraints in CCU, maintaining privacy was difficult. The use of privacy screens was not always effective.
- FFT results were lower than then England average, the PLACE scores were for food and cleanliness were high.

RESPONSIVE

- The Minor Injuries unit at SH used to be a full emergency department. Ambulance services no longer brought patients identified as majors to the hospital, however, the local population needed additional education regarding the service change at that site. Ambulances did bring patients directly to the AMU.
- SH did have the ability to care for paediatrics until they could safely be transferred, by on site anaesthetist.
- Access and flow was an issue. Bed occupancy rate was 95%. Discharge arrangements needed to be strengthened, as bed occupancy was high. For instance, a number of patients needed to be cared for outside of CCU due to there being a lack of beds. We also saw medical outliers one of which had not been seen by a doctor for six days from admission.
- Referral to treatment times did not always meet national targets. However, we did see that was an improving picture.
- The trust was not meeting its own policy regarding responding to complaints. Following a governance review the trust had worked hard to reduce the backlog of outstanding complaints.

WELL LED

- The Chair and CEO were interim and put in place to support the trust to achieve national targets and financial stability.
- There had been changes in the structure of the senior management and divisional structural changes too. Staff were positive about the changes and the visibility of senior management on their units.
- Staff understood the vision and values and how they contributed to the objectives set by the trust. Staff were involved in identifying the values they worked towards also.
- The governance structure was organised so that ward to board and visa versa communication was effective.
- We noted that black and minority ethnic staff were under- represented from band 8 and above and on the board.
- The trust had implemented a programme to ensure that STAT antibiotics were given within an hour of prescribing. The programme was a success and had been rolled out to include Parkinson medication, with good results.

Areas of outstanding practice include:

Summary of findings

- The trust approach to an 'Executive Root Cause Analysis' meeting where robust professional and management challenge is centred on supporting learning from incidents.
- The trust employed a nurse educator for the ED specifically to ensure nursing staff are competent practitioners. Newly qualified staff had a local induction and a period of preceptorship. Newly qualified staff that we spoke to told us that they received very good support.
- We saw an example of outstanding practice in the imaging department. There was an excellent induction document introduced by senior imaging managers. This gave radiographers opportunities to reflect on their practice and innovative ways of thinking about how they work. After staff had completed the induction, a discussion took place between the radiographer and the on-site lead. This also ensured staff had the necessary knowledge to practice safely.
- Infection prevention and control practices at the Runcorn Road Dialysis unit were systematic, thorough and embedded. The unit and its equipment were spotlessly clean.
- Tuberculosis services had received national recognition for their work in decreasing the number of failed appointments and improving engagement of patients from certain minority groups.

The trust MUST:

- Improve infection prevention and control practices amongst its staff in some locations.

- Within the emergency department at BHH the trust must ensure that the premises is suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time.
- The trust must consistently ensure medicines are stored appropriately and are suitable for use.
- The trust must ensure staff are trained and competent to administer medicines under PGDs.
- The trust must review and improve security and access arrangements at the at Castle Vale Renal Unit.
- The ED at Good Hope Hospital must ensure they follow policies and procedures about managing medications; including storage, checking medications are in date, and safe disposal of medications.

The trust SHOULD:

- Improve its BME representation at senior management levels within the organisation.
- Staffing levels did not meet the trust's agreed establishment. The trust should ensure sufficient staff (medical and nursing) in its substantive establishment to avoid the overreliance on agency staffing.
- Improve its response to complaints to meet the targets the trust has set itself.
- Continue to improve its board governance process; particularly with regard to the board assurance framework and board visibility of lower level risks.

Please note all the 'Musts' and 'Shoulds' can be found at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Heart of England NHS Foundation Trust

Heart of England Acute sites

- There are just over 1300 beds at this hospital at the time of our inspection.
- This trust is a Foundation Trust, this means
- At the time of the inspection the trust was starting the process to seek approval to merge with University hospitals Birmingham Foundation Trust.
- The trust has three acute sites situated in the east, north and southeast of the city of Birmingham. Catering to a wide demographic population
- We used the intelligence we held about the hospital to identify that we needed to inspect of the Emergency department (ED), Medicine, Surgery, Critical care and Outpatients and diagnostic imaging. In relation to Critical Care we inspected this service as it had been rated good previously and wanted to see if it had improved further.
- We have inspected because we needed to be assured that the trust was on an improvement

trajectory. Intelligence from the trust and nationally available reports along with information from the public, helped us to identify the services for which we had concerns.

- The trust had two dialysis satellite units within the community, offering 57 dialysis stations to support people with acute kidney failure. Both were nurse led units, supported by the main unit within the hospital (we did not inspect the hospital unit).
- Patients referred to the service are supported to stay at home following admissions and to prevent further admissions by teams of multidisciplinary staff based in the community. This was mostly based in the Solihull area.
- The trust also has a dedicated chest clinic service which operates from the centre of Birmingham offering a number of specialist clinics including Rapid Access for suspected lung cancer, Occupational lung disease, Tuberculosis (TB) and Thoracic surgery.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

Inspection Manager: Donna Sammons, Care Quality Commission

The inspection team also consisted of 12 Acute Inspectors, 2 Medicines Inspectors and 2 Assistant Inspectors. We were also assisted by 21 specialist advisors.

How we carried out this inspection

Heart of England NHS Foundation Trust (the trust) was inspected previously in December 2014 as part of an unannounced responsive inspection. The trust was in breach with regulators Monitor,

and we had received intelligence which warranted our response and so we arranged an inspection. The

inspection took place between 08 and 11 December 2014 and focussed on A&E, Medicine, Surgery, Maternity and Outpatients Departments on all three sites. The trust was rated as requiring improvement in December 2014.

Due to further undertakings by Monitor in which an interim management team was appointed at the trust and in addition to intelligence gathered by the CQC, we

Summary of findings

undertook an unannounced inspection on 06 September 2016 which formed part of, and informed a short noticed focussed inspection which took place between 18 and 21 October 2016. The inspection covered medical care, surgery, urgent and emergency services and outpatient and diagnostic imaging services across the trust. We also inspected community services for adults, the Birmingham Chest Clinic, Castle Vale Renal Unit and Runcorn Road Renal unit.

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?

Before our inspection we reviewed a range of information we held about the trust and asked other organisations to share what they knew. These included Clinical

Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

As part of our inspection, we held focus groups and drop-in sessions with a range of staff in the trust including nurses, trainee doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from ward areas and outpatients services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the trust.

What people who use the trust's services say

- The trust performed 'about the same' as other trust's in the 2015 CQC Inpatient Survey for all but four questions. The trust performed worse than other trust's for the questions in relation to; Help with eating, staff teamwork, consideration by staff of a patient's home and family situation upon discharge and care provided by staff.
- The trust performed similar to the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to Food, Privacy/dignity/wellbeing and Facilities. The trust saw an improvement in Cleanliness, Food and Facilities in 2016 compared to the previous year 2015.
- The trust's Friends and Family Test performance (% recommended) was slightly below the England Average between August 2015 and July 2016. In latest period, August 2016 the trust performance was 94% compared to the England average of 95%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trust's for one of the 50 questions, in the middle 60% for 48 questions and in the bottom 20% for one question. The trust showed a 7% improvement in 2014/15 for having enough nurses on duty from the previous year for 2013/14.

Summary of findings

Facts and data about this trust

The health of people in Birmingham and Solihull is worse than the England average. Deprivation is higher than average and about 29% (72,000) children live in poverty. Life expectancy for both men and women is lower than the England average.

The health of people in Solihull is better than the England average. Deprivation is lower than the England average and about 16% (6,000) children live in poverty. Life expectancy for both men and women is higher than the England average.

The trust's main CCG (Clinical Commissioning Group) is NHS Birmingham Cross City.

This trust has four main locations:

- Good Hope Hospital
- Heartlands Hospital
- Solihull Hospital
- The Birmingham Chest Clinic

Activity and patient throughput for the 2015/16 year the trust had:

- 223,189 A&E attendances.
- 201,347 inpatient admissions.
- 2,482,230 outpatient appointments

- 60,525 surgical bed days.

The trust employed 9,120 staff.

Of this there were 3,057 nurses, 1,002 medical staff and 580 allied health professionals

The trust had a budgeted establishment of 10,322 staff.

The financial position 2015/16

- Income £682.9m
- Underlying Deficit of £65.6m
- The trust predicts that it will have a deficit of £11m in 2016/17.

In addition to standard specialties at the trust, they also provide the following Specialist services at the Birmingham Chest Clinic;

- Allergy Services
- Chest X-Ray Service
- General Lung Disease
- Rapid Access for Suspected Lung Cancer
- Occupational Lung Disease
- Tuberculosis (TB)

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Summary</p> <p>We inspected ED, Medical care, Surgery and OPD DI both in 2014 and this inspection. Surgery in the 2014 inspection did not receive a rating which was an internal CQC issue. We also inspected Critical care unit (CCU) at Birmingham Heartlands during this inspection.</p> <p>Emergency Department</p> <p>At Birmingham Heartlands Hospital (BHH) during this inspection, we rated the safe domain as inadequate; this was a deterioration from the last inspection when it was rated as requires improvement.</p> <p>At Good Hope Hospital (GHH) during this inspection, we rated ED as requires improvement which was the same as the previous inspection.</p> <p>At Solihull Hospital (SH) we rated ED as good, which was an improvement from the last inspection.</p> <p>Medical Care</p> <p>At BHH we rated this domain as requires improvement, this was the same as at the previous inspection.</p> <p>At GHH and SH we rated this domain as good which was an improvement from the last inspection where we rated the service as requires improvement.</p> <p>Outpatients and diagnostic imaging</p> <p>Both BHH and GHH received a good rating which was an improvement from the last inspection, where they were rated requires improvement.</p> <p>At SH we saw that this core service was rated the same at both this and the last inspection being good in both instances.</p> <p>Surgery</p> <p>At both BHH and GHH we rated the safe domain as requires improvement. SH was rated as good.</p> <p>Critical Care unit</p> <p>We rated this core service domain as good. We did not inspect this in 2014.</p> <p>Community based services</p>	

Summary of findings

Chest Clinic, Runcorn Road Dialysis, Castle Vale Renal unit and Community adult services were all rated good for the safe domain.

We found that:

- We saw a mixed approach to infection prevention and control. Whilst we observed good practice in many areas we saw poor practice from both medical and nursing staff in some areas at GHH and BHH. We saw poor practices from the theatre staff at GHH.
- The trust was unable to meet its planned staffing establishment. With the exception of senior nurses (Band 8 and above) there was an approximately 14% shortfall between planned staffing and the trust's establishment.
- The trust relied heavily on agency nursing staff.
- The trust was unable to meet its Consultant and other medical staff establishment with a 16% and 24% shortfall respectively.
- The trust had reported five never events between August 2015 and July 2016.
- We saw that feedback to staff to allow learning from incidents was not always taking place across the trust.
- Appraisal rates for staff were lower than the trust's target for allied health professionals.

However:

- We saw good safeguarding processes and training in safeguarding met or exceeded the target in all levels.
- We saw a robust process to review incidents (the executive RCA group) which staff told us they found helpful to identify improvements.
- Morbidity and Mortality reviews were held across the trust.
- We saw a strong approach to duty of candour.

Incidents

- The trust had a policy and an electronic system for the reporting and management of incidents.
- Staff in all areas were aware of the types of incident they should report and were able to give us recent examples where they had reported them.
- Incident reporting awareness training was 100% across the trust.
- In December 2014 we found that feedback to staff to allow learning following incidents was not always taking place. The trust has since reviewed its incident reporting processes and

Summary of findings

during inspection there was evidence that incidents, including serious incidents, were investigated. Any lessons learnt as a result were fed back to staff that were involved and shared more widely to prevent recurrence.

- The trust had implemented an Executive Root Cause Analysis group where divisions were able to escalate exceptional incidents to be discussed at senior management level. Staff involved in the incidents discussed were invited to attend the meetings which enabled professional robust challenge and trust wide learning. Staff told us that they felt positive about this and felt that the process was constructive.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between August 2015 and July 2016 the trust reported five incidents which were classified as Never Events; these consisted of two wrong site blocks, one wrong site surgery, one retained foreign object, and one wrong route administration.
- In accordance with the Serious Incident Framework 2015, the trust reported 353 serious incidents (SIs) which met the reporting criteria set by NHS England between August 2015 and July 2016. Of these, the most common type of incident reported was Pressure ulcer meeting SI criteria with 75% (268).
- There were 14,821 incidents reported via the National Reporting and Learning System (NRLS) between August 2015 and July 2016. There were five deaths reported by the trust over the period. The proportion of incidents that were listed as severe was lower than the England average. During this period NRLS incidents were reported at a rate of 6.9 per 100 admissions, this was lower than the England average of 8.8 per 100 admissions.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- The trust had a process in place to fulfil its obligations in relation to the duty of candour regulations.

Summary of findings

- There was evidence that the trust was open and honest with patients in the serious incidents we reviewed. Records showed that a formal apology had been given as required, along with an explanation of the actions that would be taken to prevent the issue happening again.
- The majority of staff we spoke to were aware of the need to be open and transparent under the duty of candour regulation.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies and procedures in place, which were accessible to staff.
- Infection prevention and control (IPC) practices were inconsistent across the services and sites inspected. We observed good IPC practice and effective surgical scrub technique in the surgical services at Birmingham Heartlands Hospital (BHH). However within surgery at Good Hope Hospital (GHH) we observed poor compliance with the trust's IPC policy, where staff were observed to be wearing surgical garments outside of the theatre environment. In addition IPC techniques were observed to be poor and inconsistently completed by both medical and nursing staff within the Outpatients Department at BHH and the Emergency Department at GHH.
- The majority of areas inspected were found to be visibly clean. However, in the Emergency Department at GHH we observed blood to be present on the floor of a cubicle which was not cleaned prior to another patient being brought into the cubicle for examination.
- IPC audits and hand hygiene audits were carried out on a regular basis across all hospital sites and community services inspected. These identified good practice and areas for improvement. Key actions were identified to be implemented by staff.
- The trust reported five cases of MRSA bacteraemia between April 2015 and March 2016. Between April 2016 and September 2016 there were an additional two cases reported. The trust reported an improvement in compliance with MRSA screening for the period July 2016 to September 2016 where they achieved the target of 90% compliance.
- Between April 2015 and March 2016 the trust reported 14 cases of post 48 hour toxin positive *Clostridium difficile* which was above the trust's target threshold for the year. Between April 2016 and September 2016 the trust reported an additional 38 cases.

Safeguarding

Summary of findings

- There were trust-wide safeguarding policies and procedures in place, which were supported by staff training.
- The trust's target for completion of safeguarding training was 85%. Data provided by the trust showed that at a trust wide level the completion rates for safeguarding children and adults level one was 98%, safeguarding children and adults level two was 95% and safeguarding children level three was 85%.
- Staff we spoke to were aware of their roles and responsibilities and knew how to raise matters of concern appropriately, including issues relating to domestic violence, child sexual exploitation and Female Genital Mutilation (FGM).
- The trust had a safeguarding team in place that provided guidance to staff.
- Staff had access to senior nurses within the hospital management team outside of normal working hours and at weekends to seek advice and guidance on safeguarding issues.

Mortality

- Mortality and morbidity reviews were held across the trust. Patient records were reviewed to identify any trends or patterns and ensure that any lessons learnt were cascaded to prevent recurrence.
- The trust reported seven active mortality outlier alerts as at September 2016. This total includes two open alerts currently being considered for follow up by CQC's expert panel and five alerts already approved for follow up. Alerts were for the following indicators; acute myocardial infarction, urinary tract infections, therapeutic endoscopic procedures on upper GI tract, gastrointestinal haemorrhage fluid and electrolyte disorders and acute bronchitis. Action plans are in place and being monitored as part of the CQC engagement programme. Please note that one outlier was for fracture of neck of femur (hip), had been investigated by the trust. The summary finding was that none of the patients received unsatisfactory care in the opinion of the panel. There were, however, areas identified for improvement from an organisational and clinical perspective ,
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse

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outcomes. A score of 1 would mean that the number of adverse outcomes is as expected compared to England. A score of over 1 means more adverse (worse) outcomes than expected and a score of less than 1 means less adverse (better) outcomes than expected. Between January 2015 and December 2015, the trust's score was 0.98, which was marginally below (better than) the expected score.

Nursing staffing

- From May 2014 all hospitals were required to publish information about the numbers of Nursing and Midwifery staff working on inpatient wards on a monthly basis.
- Data provided by the trust in October 2016 showed the actual level of whole time equivalent (WTE) staff in post in comparison to the planned levels. The actual level of senior nursing and midwifery staff (band 8 and above) in post was 144.5 WTE which was higher than the planned level of 134.6 WTE. For middle grade nursing and midwifery staff (band 7 and below) the actual level was 2,891.2 WTE which was lower than the planned level of 3,290.4 WTE. For other non-medical, clinical staff (including health care assistants) the actual level was 2180.0 WTE, which was lower than the planned level of 2489.1 WTE.
- Between October 2015 and September 2016 across all services inspected, there was an average of 15.7% nursing and agency bank staff use. Rowan Ward, a geriatric medical ward at BHH had the highest percentage of nursing and agency bank staff use with an average of 69.6% over the same period. In addition, theatres 6 and 7 at BHH had 41.5% nursing agency and bank staff use.
- The average appraisal rate for nursing and midwifery registered staff across all services trust wide was 84% as at September 2016, however for allied health professionals the rate was lower at 68%.
- August 2016 board report demonstrated that recruitment time to hire was averaging 8.2 weeks. Sickness rate was 4.2%, which was an improvement, and turnover had increased slightly to 9.5%.

Medical staffing

- Data provided by the trust in October 2016 showed the actual level of whole time equivalent (WTE) staff in post in comparison to the planned levels. The actual level of consultant grade

Summary of findings

medical staff in post was 409.4 WTE which was lower than the planned level of 477.1 WTE. The actual level of medical staff of other grades (including doctors in training) was 592.3 WTE which was lower than the planned level of 734.7 WTE.

- Between October 2015 and September 2016 across all services inspected, there was an average of 7.7% medical agency use. The highest use of medical agency staff was in acute medicine (22.7%), accident and emergency (21.9%), elderly medicine (18.3%) and gastroenterology (15%).
- Data provided by the trust in October 2016 showed that the average medical staff turnover was 4.7% across the services inspected. The areas with the highest rates of medical staffing turnover were accident and emergency (44.3%), elderly medicine (25.3%) and acute medicine (21.6%).

Are services at this trust effective?

Summary

When we inspected the trust in 2014, we did not inspect the domain of effective. We did not have any information that gave raise to concern at that time. For this inspection, we wanted to look at the effective domain for the core services we were inspecting to get an overall rating for the five domains.

Emergency Department

During this inspection we found that ED at BHH was requires improvement. At GHH and SH both effective domains were rated as good.

Medical Care

Medical care at BHH and GHH sites were rated as good , with SH being rated as good for the effective domain.

Surgery

Surgery was rated good at both BHH and SH, with GHH rated as requires improvement.

Critical Care

Critical care was rated good for this domain.

Outpatients Department and Diagnostic Imaging

OPD DI was not rated we inspect but do not rate this domain.

Community based services

Summary of findings

Chest Clinic , Runcorn Road Dialysis, Castle Vale Renal unit and Community adult services were all rated good for the effective domain.

- Care and treatment was evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.
- There was good use of clinical audit to monitor and improve performance. Where audits highlighted areas for improvement the trust developed, implemented and monitored action plans.
- Outcomes throughout the trust were generally above; or, similar to national averages, although there was some poor performance in some areas.
- Effective multidisciplinary team (MDT) working was established across the majority of wards and departments we inspected.

Evidence-based care and treatment

- Care and treatment was generally evidence-based and the policies and procedures, assessment tools and pathways followed recognised and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE) and the relevant Royal Colleges'. However, the critical care service was not fully compliant with NICE guidance 83, "Rehabilitation after Critical Illness." NICE guidance 83 is a core standard for intensive care units which recommends that there is one full time physiotherapist for every four critical care patients.
- Clinical pathways and care bundles were used to ensure appropriate and timely care for patients in accordance with nationally recognised standards. However, care bundles were not consistently implemented. For example, staff within medical care at GHH were observed to not adhere to the sepsis screening tool, pathway and its management.
- Policies and procedures reflected current national guidelines and staff could access them as required via the trust's intranet.
- In Community Health Services for Adults there was evidence of reviews of audits to measure and improve quality on a monthly basis at quality and performance meetings. However, at the time of inspection, patient outcomes were not being measured at Runcorn Road and Castle Vale Renal Units.
- In the emergency department, a range of evidence based clinical care pathways were available. These included fracture neck of femur, sepsis and stroke. Patients were placed on

Summary of findings

appropriate pathways as soon as their condition was diagnosed which ensured that they received timely and appropriate interventions. The trust had implemented a new teaching programme in relation to sepsis care in order to improve on the sepsis care being provided which included the completion of sepsis audits to improve the overall uptake of the sepsis screening tool and sepsis 6 at the point of triage within the acute medical unit and emergency departments.

- Between April 2015 and March 2016 there were 34 national clinical audits and two national confidential enquiries that covered relevant services that Heart of England NHS Foundation Trust provides. The trust participated in 97% of national clinical audits and 100% national confidential enquiries which it was eligible to participate in.
- In addition to participation in national audits, each division held a local clinical audit plan. There was evidence that the results of local clinical audits were reviewed by the trust with actions being implemented to improve the quality of healthcare provided.

Nutrition and hydration

- Records showed that patients had an assessment of their nutritional needs using the Malnutrition Universal Screening Tool (MUST) and were referred to a dietician where indicated. Data provided by the trust showed that between October 2015 and August 2016 there was an average of 98% completion rate for nutritional assessments and 95% referral to dieticians where indicated.
- Staff in surgical services managed the nutrition and hydration needs of patient's well, both pre and post operatively. Staff used age appropriate nutrition monitoring tools in line with British association for parenteral and enteral nutrition (BAPEN) guidance.
- The trust hosted a Nutrition and Hydration Week in March 2016 to encourage patients, visitors and staff to choose a healthy diet.
- A coloured tray and jug system was in place to highlight which patients needed support with eating and drinking. The red tray and cup allowed ward staff to easily identify those patients who were at risk of dehydration or malnourishment and enables the staff to ensure the appropriate level of assistance and support is offered to patients.
- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns.

Patient outcomes

Summary of findings

- There was clear evidence of involvement in local and national audit. Outcomes throughout the trust were similar or above national averages, although there were some areas for improvement. Where areas for improvement were identified the trust had implemented actions to achieve this. For example; the Elderly Care Team at BHH had streamlined its process for admitting fractured neck of femur patients to an orthopaedic ward within four hours of admission. Staff achieved this by ensuring that senior clinicians within trauma and orthopaedics were contacted directly by the on-call doctor regarding confirmation of a hip fracture x-ray in the Emergency Department rather than waiting for the ward round or review by a registrar.
- The Joint Advisory Group (JAG) on gastrointestinal endoscopy is a quality improvement and service accreditation programme for gastrointestinal endoscopy. They support and assess endoscopy units to meet and maintain the JAG standards, offering assurance of quality of the service. At the time of inspection, the trust was not JAG accredited. This was due to the endoscopy unit consistently breaching its eight-week referral time. However, the trust was working very closely with JAG to regain this accreditation. The trust had introduced measures such as a vanguard mobile endoscopy unit to mitigate the breaches. This delivered 10 additional sessions a week. The trust had also introduced a number of locum gastroenterologists to support inpatient and outpatient diagnostic services.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attacks. The trust scored better than the England average in the majority of measures, however, the percentage of eligible patients admitted to a cardiac unit or ward at Good Hope Hospital was 8.3% lower than the England average of 55.6%.
- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. The Heart of England NHS Foundation Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade C in the audit from January 2016 to March 2016 which was a reduction from the grade B result achieved between October 2016 to December 2016. The performance indicator measuring standards by discharge was the lowest result for the trust (grade D), however, in the indicators measuring scanning, occupational therapy and discharge processes the trust achieved the highest level (grade A).

Summary of findings

- The trust's results in the 2015 Heart Failure Audit were better than the England and Wales average for all of the four of the standards relating to in-hospital care, in particularly Cardiology inpatient services. The results relating to discharge were better than the England average for three of the seven standards, however, three standards relating to discharge were worse than the England average in particular in relation to referral to Cardiology for follow up where the trust achieved 40% at BHH and GHH and 49% at SH. The national average for referral to Cardiology for follow up was 54%.
- In the national diabetes inpatient audit 2015, the trust scored better than the England average in 14 metrics and worse than the England average in 20 metrics.
- The trust participated in the 2015 National Hip Fracture Audit. The risk adjusted 30 day mortality rate fell within the expected limit. For BHH the mortality rate was 7.4% which was an increase over the 2014 rate of 6.6%. For GHH the mortality rate was 7.7% which was an improvement over the 2014 rate of 8.9%. The national standard for patients receiving surgery on the day or the day after admission is 85%, both BHH and GHH were below the standard, achieving 62.2% and 68.8% respectively. The perioperative medical assessment rate was 96.9% for BHH and 82.9% for GHH which is below the national standard of 100%. The audit results showed that the trust was in the best 25% of trust's nationally for the indicator related to the proportion of patients who did not develop pressure ulcers.
- Performance in the Patient Reported Outcome Measures (PROMs) audit for the 2015/16 financial year was better than the England average for groin hernias and varicose vein. The audit showed that the trust performed worse than the England average for hip replacement and knee replacement.
- Between March 2015 and February 2016 there was a higher than expected risk of readmission for elective admissions in cardiology and gastroenterology. For non-elective admissions there was a higher than expected risk of readmission in general medicine and rheumatology.
- In urgent care services, the unplanned re-attendance rate within seven days was consistently worse than the national standard of 5%. Between September 2015 and August 2016 the trust's performance was 7% which was slightly better than the England average for the same period (8%).
- In surgical services the trust had a higher than expected risk of readmission for both non-elective and elective admissions between March 2015 and February 2016. General surgery had the largest risk of readmission.

Summary of findings

- The critical care units at BHH contributed to the Intensive Care National Audit and Research Centre (ICNARC) patient outcomes database. The data demonstrated that the Heartlands Hospital performed similarly to other comparable hospitals with the exception of 'risk adjusted hospital mortality rate which was identified as higher than the expected range.
- In outpatients, the trust's rate of follow up appointments in relation to new appointments was similar to the England average between April 2015 and March 2016.

Multidisciplinary working

- Effective multidisciplinary team (MDT) working was well established across the wards and departments inspected. It was evident from discussions with staff, observations of inspection and reviews of records that there was a joined-up and thorough approach to assessing the range of people's needs.
- Assessments were focussed on securing good outcomes for patients in all of the services we inspected; they were regularly reviewed by all team members and kept up to date.
- It was evident that professionals from all disciplines valued each other's contribution and that relationships between them were positive and productive.
- In community health services for adults, patients could access all professionals relevant to their care through a hub system of integrated multi-disciplinary teams (MDT). The involvement of other organisations and the local community was integral to how services were planned and ensured that services met peoples' needs.
- Specialist nursing staff provided support for community clinics and professional advice for district nursing colleagues to support multi-disciplinary working and the use of best practice for patients. For example, the tissue viability team or the falls risk team. Nursing staff told us they felt well supported by other professional staff that provided multi-disciplinary support.
- The Rapid Assessment Interface and Discharge (RAID) team provided mental health services and worked closely with staff to ensure patients were supported on discharge. Staff across all areas told us that they had access to this team and we saw examples of them working well with ward staff. For example, on ward 9 at GHH, we observed a psychiatric patient who required 2:1 registered mental health nurse ratio. We reviewed the patient's notes. The mental capacity act paperwork was in place, completed correctly and signed. We saw evidence that the RAID team had assessed the patient in a timely manner.

Summary of findings

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.
- Staff had knowledge and understanding of procedures relating to Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interests of the person, and there is no other way to look after them. This includes people who may lack capacity.

Are services at this trust caring?

Summary

During our 2014 inspection we did not inspect the caring domain. For this inspection, we wanted to look at the effective domain for the core services we were inspecting to get an overall rating for the five domains.

Within ED caring was rated as requires improvement at BHH, we found that at both GHH and SH, caring was rated at good.

Medical care, Surgery and OPD DI across all three acute sites was rated good.

Critical care was rated good for this domain.

The caring domain for the Chest Clinic , Runcorn Road Dialysis, Castle Vale Renal unit and Community adult services were all rated good.

- Care and treatment was delivered by caring, committed, and compassionate staff. Staff in all disciplines treated patients and those close to them with dignity and respect.
- Staff were open, friendly and helpful, many went out of their way to help and support patients.
- Patients were positive about their interactions with staff. We saw some excellent examples of staff 'going the extra mile' and providing care in an individualised and person-centred way.
- Staff actively involved patients and those close to them in the planning of their care and treatment. Patients felt included and valued by staff.

Compassionate care

Summary of findings

- Care and treatment was delivered by caring, committed, and compassionate staff. Staff at all grades treated people with dignity and respect. Patients were very positive about their interactions with staff.
- Staff were open, friendly and helpful, many went out of their way to help and support patients.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trust's for one of the 50 questions, in the middle 60% for 48 questions and in the bottom 20% for one question. Areas of good performance included the doctor having access to the correct notes and other documentation at the time of the appointment and the patient being able to bring a family member or friend with them. Areas of below average performance included the question in relation to patients being able to discuss worries or concerns with staff during their visit.
- The trust performed better than the England average in the Patient Led Assessments of the Care Environment (PLACE) survey 2016 for cleanliness (99% achieved, national average 98%) and food (93% achieved, national average 88%). The trust achieved 78% for privacy, dignity and wellbeing which was below the national average of 84%. The trust achieved 92% for facilities which was below the national average of 93%.
- The trust performed about the same as similar trust's in all areas of the 2015 CQC inpatient survey for all but one question. The trust performed worse than similar trust in relation to patients receiving enough help from staff to eat their meals, however, since the survey, a coloured tray system has been introduced in order that staff are aware of patients requiring assistance at mealtime.
- Friends and family test performance at the trust was worse than the England average each month between October 2015 and September 2016. In September 2016 the trust performance was 94% compared to the England average of 95%.

Understanding and involvement of patients and those close to them

- Patients and those close to them were encouraged and supported to be an active partner in their care.
- Patients and those close to them confirmed that staff kept them informed about their treatment and took in to account their wishes and preferences when delivering care and treatment. Information about care and treatment was provided in a manner they understood.

Summary of findings

- We observed positive interactions between doctors, nurses and patients on all wards visited. We saw doctors explaining procedures and treatment plans to a patients using simple language that helped them to understand.

Emotional support

- Staff recognised that meeting people’s emotional needs was important and they were sensitive and compassionate in emotional or stressful situations.
- Some services had developed their own resources to help provide emotional support to relatives. For example, older people’s services used best practice guidance from the Alzheimer’s Society and Dementia UK to help relatives and friends of patients understand complex mental health needs and signpost them to support.
- The respiratory and Cystic fibrosis ward had their own psychologist/counsellor and social worker to give all round emotional and practical support to their patients.

Are services at this trust responsive?

Summary

During this inspection we found that outpatients and diagnostic imaging achieved a good rating at BHH and GHH. ED, Medical care, Surgery and Critical care (BHH only) were rated as requires improvement. Whereas at the smaller acute site of SH all services inspected were rated as good for responsive.

For ED at BHH during our 2014 inspection we rated the domain as inadequate. Therefore, we found an improvement during this inspection giving rise to the rating of requires improvement. At GHH the rating remained the same for both inspections achieving a rating of requires improvement. SH responsive domain had improved from our previous 2014 inspection where we rated them as required improvement. At this inspection we rated them as good.

Medical care at both BHH and GHH had rating of requires improvement which was the same as at our previous inspection, with no increase in the rating achieved. SH medical care had improved from the rating they had achieved.

OPD DI at all three acute sites was rated good this was an increase from the previous inspection where they were rated as requires improvement.

Surgery was rated as requires improvement for both BHH and GHH.

Critical care was rated requires improvement during this inspection.

Summary of findings

Chest Clinic , Runcorn Road Dialysis, Castle Vale Renal Unit and Community adult services were all rated good for the domain of responsive. We found that:

- The trust was able to meet the 2 week wait standard (urgent GP referral for suspected cancer).
- The trust was able to meet the 31 and 62 day cancer standard.
- The trust met the referral to treatment standard in surgical services.
- Length of stay in elective patients within medical care was shorter than the England average.

However:

- The trust was unable to meet the national 4 hour A&E standard for a number of years.
- The trust was unable to meet the referral to treatment standard in medical care services.
- Whilst the trust's response to complaints was improving; only 18% of complaints (August 2016) were responded to within the trust's own 30 day standard.

Service planning and delivery to meet the needs of local people

- The trust had a wide range of services in place to meet the needs of its population across a wide geographical area. It was noted the service had worked within its commissioning arrangements to streamline some services and make best use of resources.
- In the emergency department at BHH senior staff told us that the service was part of the system resilience group, a regional group looking at emergency care resilience. The group was made up of hospitals, clinical commissioning groups, GPs, local councils and NHS England. The aim of the group was to look at the regional health economy and discuss ways of working together to benefit all who used the services.
- The Minor Injuries Unit (MIU) at Solihull Hospital provided a local facility for patients to attend a 24 hour service with minor illness or injury. The MIU had previously been designated as a full emergency department. It was acknowledged that there was some confusion amongst local residents as to the services provided at the MIU due to the road signage near to the site, which at the time of inspection indicated that there was a fully functioning emergency department on site.
- The trust provided a wide range of general and specialised surgical services to both the local and regional population. The trust had consulted local communities in discussions around

Summary of findings

the configuration of surgical services across each of the trust sites. In order to deliver the best surgical care, the trust were reviewing the potential benefits of centralising surgical specialities at hospitals within the trust. As part of the review, it was recognised that there was an increase in the number of people living with dementia being admitted for orthopaedic surgery. The trust had recruited an ortho-geriatrician in order to meet this changing demand.

- It is recognised that tuberculosis (TB) often affects multiple members of the same family. The Birmingham Chest Clinic was seen to provide both paediatric and adult TB clinics on the same day. This enabled all affected family members to be treated on the same date, therefore avoiding the need for multiple visits to the clinic for families.
- Community Health Services for Adults utilised a “Community Hub” model of integrated care. This ensured that patients received improved outcomes by reducing the number of health professionals that they needed to interact with, reducing duplication of work and easing patients transition from hospital to home through the effective use of integrated care pathways. For example, in 2015, a Rapid Response Team (RRT) was implemented. The RRT formed part of the community hub and provided 24 hour care to prevent patients living in their own homes and under the care of their GPs from being admitted into hospital if they became unwell and were safe to remain at home.

Meeting people's individual needs

- There was a pathway for patients living with dementia or a learning disability which guided staff on how best to treat and meet the needs of these patients this pathway would follow the patient throughout their hospital journey. Staff also had access to specialist teams for advice and support.
- For those patients living with dementia or a learning disability, there were link nurses to support patients, families and staff.
- The trust used, “This is me,” booklets which gave staff information about patients living with dementia, including their likes and dislikes. Staff asked relatives and carers who knew the patient well to complete the booklet. This enabled staff to deliver care to meet the patient’s individual needs.
- The trust had an active mental health research portfolio which had been expanded to include further research in the area of dementia.
- There were volunteers available to support vulnerable people receiving treatment in the emergency departments.

Summary of findings

- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they were able to access these services as required. In addition at the Birmingham Chest Clinic and Castle Vale Renal unit, we observed that nursing staff were able to speak a number of languages and that this was taken into account when designating a lead nurse to a patient.
- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric (obese) patients.

Access and flow

- Bed occupancy rates trust-wide, delayed transfers of care and discharges had an impact on the flow of patients throughout the trust.
- Between quarter 4 2014/15 and quarter 1 2016/17, bed occupancy rates were consistently above the England average of 90%. In quarter 1 2015/16, the bed occupancy rate reached 95.2%. This meant there were more patients needing medical beds than were available. Evidence has shown that when bed occupancy rises above 85% then it can start to affect the quality of care to patients and the orderly running of the hospital.
- At the time of inspection, in medical services at BHH there were 14 medical outliers. A medical outlier is a patient who is admitted to other wards when there is no appropriate medical bed available. The inspection team found that one of the medical outlier patients had not been re-visited by a doctor since their initial admission six days previously.
- The respiratory ward at BHH had developed a discharge planning board which had proved to be an effective discharge tool and as such had been adopted across the trust.
- There is a Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival. The trust provided data that showed it had been in a position of non-compliance with the emergency department standard of 95% for a number of years. Given this situation, although considerable investment and planning has gone into remedial actions, performance remained below the required regulatory and contractual levels.
- Between 1 September 2015 and 31 August 2016, information provided by the trust showed that the bed occupancy for

Summary of findings

critical care was 90%. The national average critical care bed occupancy was 86%. Staff told us that matching demand with capacity was an on-going challenge. Staff told us there were occasions, which required patients to be cared for outside critical care such as within recovery or on a ward with the support of a clinical outreach nurse. Information provided by the trust identified between 1 September 2015 and 31 August 2016 50 patients were cared for outside ITU/HDU for more than four hours when a need for a critical care was identified.

- Between July 2015 and June 2016 the trust's referral to treatment time (RTT) for admitted pathways for Medical services was worse than the England average overall performance. In September 2016, 94% of this group of patients were treated within 18 weeks. Cardiology, Neurology, Thoracic Medicine and Rheumatology performed above the England averages for RTT. Dermatology, Gastroenterology, General Medicine and Geriatric Medicine were worse than the England averages for RTT.
- In surgical services, performance for national RTT targets were similar to the England averages. In September 2016, across all surgical specialities, the trust achieved 68% of patients being treated within 18 weeks, compared to the England average of 71%.
- Between 1st April 2015 and 31st March 2016 the average length of stay for Medical elective patients at the Heart of England NHS Foundation Trust was 0.4 days, which is better than the England average of 3.9 days. For Medical non-elective patients, the average length of stay was 5.2 days, which is better than the England average of 6.6 days.
- The percentage of people seen by a cancer specialist within two weeks of urgent GP referral was 91.4% between April 2015 and March 2016. This was worse than the national target of 93%.
- Between April 2015 and March 2016 the percentage of patients receiving their first definitive treatment for cancer within 62 days of urgent referral by GP or dentist was 82.91% which was below the national target of 85%. However, 95.93% of patients who were urgently referred from the National Screening Service received their first definitive treatment within 62 days which was above the national target of 90%.
- Between April 2015 and March 2016, the percentage of people waiting less than 31 days from diagnosis to first definitive treatment for all cancers was 98.75%, which was better than the national target of 96%.

Learning from complaints and concerns

Summary of findings

- There was a trust-wide policy in place for managing concerns and complaints. Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Staff would deal with complaints informally if possible to aid timely resolution for the complainant.
- There was a historical backlog of complaints at the trust. Following a review of the complaints processes and systems, complaint management was incorporated into the Chief Nurse's portfolio in October 2015. A new policy was introduced which established a 30 working days standard for complaint responses. Most recently the Trust responded to 18% of formal complaints within this timeframe (August 2016 data). This has been a gradual improvement since May 2016 (11%). The Trust has a historical backlog of complaints which has impacted on timeliness and various changes, including a centralised complaints function, have been made to address this and cross divisional support to close outstanding complaints was in progress at the time of inspection.
- The Chief Nurse is the executive lead for complaints, with day to day responsibility sitting with the Head Nurse (Patient Experience) and the Head of Patient Services.
- At the time of inspection, there was one vacant post with the trust's complaints team which totalled approximately 17 staff.
- Divisional Quality and Safety Committees reviewed complaint handling and response rates, this data was then reported monthly to the trust board as part of a monthly quality report.
- The trust had implemented a Chief Executive RCA Group in which specific cases were discussed at a senior level. Divisions nominated the cases to escalate to this group, and staff involved were invited to the meeting. The group helped to improve the dissemination of learning across the trust.
- Managers discussed information about complaints during staff meetings to facilitate learning. Key learning was also shared
- Information about complaints procedures were available in all areas we visited. There were details on cards and leaflets about the patient advice and liaison service (PALS) in the hospital sites inspected, however, Community Health Services for Adults were not providing this information to patients in the community.

Are services at this trust well-led?

Summary

Summary of findings

We have considered it correct to give the trust an overall rating for the well-led domain only. We undertook our inspection activity at both a local and trust wide level. We conducted interviews with the senior and executive management team. We felt we had enough information to rate the trust performance in this domain.

At SH we rated well-led good for ED, Medical care, this was an improved rating for all. We rated OPD DI requires improvement which was the same as the previous inspection. Surgery achieved a rating of requires improvement in well-led.

At BHH the ED and OPD DI had both improved, being rated this time as requires improvement and good. Medical care had stayed the same and was rated as requires improvement. Surgery was rated requires improvement and critical care was rated good.

At GHH ED remained the same with a rating of requires improvement. , Medical care and OPD DI was rated good which was an improvement on the previous inspection where they were both rated as requires improvement in 2014. Surgery we rated as good.

The well-led domain for Chest Clinic, Castle Vale Dialysis and Community adult services were all rated good. Runcorn Road Dialysis achieved an outstanding for well-led.

We rated the trust as Good for Well-led because;

- We saw a strong theme of improvement and control from the new leadership of the trust.
- We saw that managers were seen by staff to be knowledgeable, approachable and supportive.
- We saw a robust vision and strategy for the organisation. Staff felt they had been involved in its development .
- Leaders were clear on the priorities and challenges for the trust.
- We saw an improving approach by the trust and its leaders to governance. More work needed to be done in this important area, but we saw the leaders of the trust were sighted on this.

However:

- The profile of BME staff in the senior management was not representative of the population it served or of the workforce as a whole.
- The Board Assurance Framework was in draft form.
- The process to ensure the board was sighted on low level risks was not robust.

Leadership of the trust

Summary of findings

- The trust was subject to NHS Improvement undertakings due to concerns surrounding its performance. An interim Chief Executive Officer and Chair were appointed in October 2015 with a focus to improve the quality of care to patients by stabilising and sustaining the operational and financial stability of the trust.
- Leaders were knowledgeable about the trust's priorities and challenges. Staff were included when considering actions to achieve and address them.
- Leaders demonstrated a commitment to quality, patient safety and continuous improvement.
- In the 2015 national NHS staff survey, staff scored support from immediate managers out of five. This score was 3.64, which was slightly below the national average of 3.7. However, in all areas we inspected, staff felt there was clear leadership from managers. Staff could explain the leadership structure within their own areas. We observed strong local leadership, with staff in renal services describing their line manager as a role model.
- Senior managers were visible at the time of the inspection and staff confirmed they visited wards and departments across the hospital sites, however, staff we spoke to in community health services for adults did not experience the same level of visibility.
- Managers were seen as knowledgeable, approachable and supportive. Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings and other staff forums.

Vision and strategy

- The trust had a vision and strategy with clear aims and objectives. A programme of work was undertaken by the trust in 2016 to launch a new vision and purpose for the organisation with accompanying values following the appointment of an interim senior management team. The trust's vision and purpose was to build healthier lives and to serve patients with excellence in care to improve the health of the communities served.
- Staff were consulted during the development stages of the trust's values. The values include; Caring – treating everyone with compassion and respect; Honest – truthful and open with all; Supportive – working together to get things done; and Accountable – taking personal and collective responsibility for doing our best.

Summary of findings

- Staff were aware of the trust's purpose, vision and values, and were able to articulate the vision and values for the trust. This vision was embedded in the trust and services strategies representing an improvement over our findings in the previous inspection of the trust in December 2014.
- The trust had strategies for individual services that were linked to the trust's overall corporate objectives, vision and values.

Governance, risk management and quality measurement

- The trust had an improving approach to governance and risk management that had been developed by the interim senior management team. The trust had completed a governance review and we saw improvements in the governance reporting and committee structure. The structure in place supported challenge and scrutiny of performance, risk and quality; however, there was opportunity for the structures to be further embedded across the trust.
- There were however, opportunities to improve oversight of actions arising from serious incidents and clinical audits, as well as the operational performance in relation to the timeliness of instigating duty of candour and reporting serious incidents.
- Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through divisional performance meetings. Staff on wards and departments had good access to performance information and were able to describe the risks and mitigating actions for their service.
- At the time of inspection divisions held individual risk registers, with exceptions being reported to board level. Divisions were accountable for implementing mitigation against the risks highlighted in their risk registers. Since only exceptions were reported to board level, the board may not be sighted on lower level risk.
- At the time of inspection, the Board Assurance Framework (BAF) was in draft format. The trust advised that further work was underway to ensure that the corporate risk register was integrated further to ensure that operational risks were recorded on the strategic risk register where appropriate. The further development of the BAF would enable the trust to identify any gaps in controls and assurance.
- Workforce shortfall was identified as a risk on the BAF, but higher rated risks included financial position, estate infrastructure, and IT infrastructure. All identified as risks to delivery of objectives.

Summary of findings

- The board received performance reports and clinical quality monitoring reports.

Culture within the trust

- Following the appointment of the interim senior management team and the subsequent re-branding, there was a positive culture throughout the trust. Staff were proud of the work they did and proud of the services they provided.
- Staff in community services for adults told us that they had not felt part of the trust when they were integrated in 2011. However, felt that the culture had changed under the direction of the interim Chief Executive Officer who, “Recognised that community services should be engaged in the same way as acute services.”
- Staff were encouraged to speak freely and to raise concerns so that action could be taken.

Equality and Diversity – including Workforce Race Equality Standard

- As part of the new Workforce Race Equality Standard (WRES) programme we have added a review of the trust’s approach to equality and diversity to our well led methodology. The WRES has nine specific indicators by which organisations are expected to publish and report as well as put action plans into place to improve the experiences of its Black and Minority Ethnic (BME) staff. As part of this inspection we looked into what the trust was doing to embed the WRES and race equality into the organisation as well as its work to include other staff and patient groups with protected characteristics.
- The equality & diversity function was overseen by the Director of Workforce. Bi-annual WRES reports were submitted to the board highlighting the performance of the trust in relation to race equality and actions required to support further improvement.
- The trust published its WRES Report as required by NHS England.
- The trust’s 2016 WRES report shows that there is a 27.9% BME representation in the overall workforce.
- No BME staff were employed within any of the 30 non clinical posts at band 8d and above.
- There were 269 senior clinical posts (band 8a and above) of which there was a 12% representation of BME staff filling those roles.
- The report also showed that BME staff were twice as likely to be subject to formal disciplinary proceedings when compared to white staff.

Summary of findings

- Across the trust, the report showed that white candidates that are shortlisted to vacant roles were 1.58 times more likely to be appointed than BME candidates.
- The trust acknowledged that it was under represented by BME staff at board level. At the time of inspection the trust was actively seeking to recruit a Non-Executive Director from a BME background.

Fit and Proper Persons

- The trust was aware of its obligations in terms of the fit and proper persons regulation. This regulation ensures that directors of NHS providers are of good character and have the appropriate skills and background to carry out their roles.
- The trust policy on pre-employment checks covered criminal record, financial background, identity, employment history, professional registration and qualification checks.
- Recruitment processes were in place and included relevant personal, professional and financial checks.

Public engagement

- The trust engaged with patients and the public in a variety of different ways, including local and national patient surveys, the NHS Friends and Family Test (FFT), patient and carer panels and contacts via the trust's Patient Advice and Liaison Service (PALS). The trust has had an increased focus on FFT to improve the engagement.
- The FFT is a single question survey which asks patients whether they would recommend the service they have received to friends and family. In the 2015/16 reporting year, the trust received approximately 205,822 responses of which 83% were positive reflections of care and treatment.
- Staff engaged with patients and their relatives to gain feedback about their experiences and the quality of services. Feedback was used to improve practice and enhance the patient experience. Nursing quality dashboards enabled wards to look at their individual patient experience data per ward, which enabled patient experience to be viewed directly at service level.
- The volunteer programme was well established and offered local residents opportunities to contribute to patient care. Volunteers were very positive about the scheme and felt valued and included by the wider staff team.

Staff engagement

Summary of findings

- Staff engagement was generally well managed and staff felt supported by leaders and managers. Staff told us in interviews and focus groups that following the appointment of the interim senior management team and subsequent restructuring of the trust's divisions, they felt engaged as part of a single trust.
- Staff were involved in decisions for making improvements to services and were given opportunities to influence the outcomes. In interviews and focus groups staff told us that they saw changes being implemented in their services as a result of improvement plans.
- All the staff we met as part of our inspection were committed and motivated to delivering compassionate care.
- Staff were positive about the methods used to seek their views, comments and ideas.

Innovation, improvement and sustainability

- At the time of inspection, the senior management team described the priorities for the trust to be to achieve financial and operational stability to the organisation. The inspection team observed and were told by staff of a number of innovative practices.
- In 2015, work in relation to reducing delays in STAT antibiotic dose administration was improved upon. An innovative automated alerting system was implemented trust wide to communicate to front line staff when antibiotic doses are due. The administration of these antibiotics is monitored via the Quality Dashboard metrics. In October 2016 the doses administered within 1 hour of the target time was 79%. This has had a major impact on the management of patients with sepsis and as such the project has received local and national recognition. The system was a finalist in the National Patient Safety and Care Awards 2015.
- The trust had introduced a similar system for the timely administration of regular Parkinson's Disease medication. If Parkinson's Disease medication is missed or delayed, a patient may deteriorate quickly. Through implementation of the alert system the administration of Parkinson's disease medication within 30 minutes of the target time has improved from 47% in 2015 to 70% in 2016.
- The trust has an active research portfolio with the use of technology to allow patients to manage their own health, reducing hospital admissions and improving patient care being the main areas of focus.

Overview of ratings

Our ratings for Birmingham Heartlands Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement				
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good

Our ratings for Good Hope Hospital

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

Overview of ratings

Our ratings for Solihull Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	Good	Good	Good	Requires improvement	Good

Our ratings for Castle Vale Renal Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good

Our ratings for Runcorn Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Outstanding	Good

Our ratings for Heart of England NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	N/A	N/A	N/A	N/A	Good	N/A

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Outpatient and diagnostic imaging services – satellite sites	Good	Not rated	Good	Good	Good	Good

Outstanding practice and areas for improvement

Outstanding practice

Areas of outstanding practice include:

Trust wide

- The trust approach to an 'Executive Root Cause Analysis' meeting where robust professional and management challenge is centred on supporting learning from incidents.
- The trust had met and exceeded its safeguarding levels of training across the organisation.
- Care and treatment was based around national guidance and standards.
- We saw an example of outstanding practice regarding the monitoring system for administering timely medication such as the first dose of antibiotics and Parkinson's medication. The system involved the nurse in charge being beeped to make them aware these times sensitive medications had been prescribed and needed to be administered.

BHH ED

- The trust employed a nurse educator for the ED specifically to ensure nursing staff are competent practitioners. Newly qualified staff had a local induction and a period of preceptorship. Newly qualified staff that we spoke to told us that they received very good support.
- The nurse educator told us in detail about the training plans for the ED nurses.

BHH OPD DI

- We saw an example of outstanding practice in the imaging department. There was an excellent induction document introduced by senior imaging managers. This gave radiographers opportunities to reflect on their practice and innovative ways of thinking about how they work. After staff had completed the induction, a discussion took place between the radiographer and the on-site lead. This also ensured staff had the necessary knowledge to practice safely.

Good Hope Hospital ED:

- The trust employed a nurse educator for the ED specifically to ensure nursing staff are competent

practitioners. Newly qualified staff had a local induction and a period of preceptorship. Newly qualified staff that we spoke to told us that they received very good support.

GHH Outpatients and diagnostic imaging:

- We saw some excellent examples of innovation. In diagnostic imaging an induction pack had been introduced for the radiographer to reflect on their practice. Following completion of the induction, a discussion took place between the radiographer and the on-site lead. This would provide the radiographer with the opportunity to reflect on their role and ensure they had the knowledge to practice safely.

Castle Vale Dialysis

- Infection prevention and control practices were systematic, thorough and embedded. The unit and its equipment were spotlessly clean.
- Staff displayed an overwhelming enthusiasm for providing the best possible care and support for each and every one of their patients.

Runcorn Road Dialysis

- Infection prevention and control practices at the unit were systematic, thorough and embedded. The unit and its equipment were spotlessly clean.
- Staff displayed an overwhelming enthusiasm for providing the best possible care and support for each and every one of their patients.
- Definitive access (using an arteriovenous fistula, graft or peritoneal catheter) rates were significantly better than the UK Renal Association's clinical practice guidelines recommended.

Chest Clinic

- Tuberculosis services had received national recognition for their work in decreasing the number of failed appointments and improving engagement of patients from certain minority groups.
- The lead nurse had written best practice article, which appeared as best practice guidance on the Royal College of Nursing website.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

The trust MUST:

Trust wide

- Improve infection prevention and control practices amongst its staff in some locations.

Birmingham Heartlands ED

- The trust must ensure that the premises is suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time.
- The trust must ensure it is doing all that is reasonably practicable to mitigate any risks in relation to patients waiting in the corridors, delays in triage and ambulance handover times.
- The trust must ensure infection control procedures including hand washing, the use of protective clothing and cleaning procedures meet the requirements to prevent the spread of infections.

BHH Surgery

- The trust must consistently ensure medicines are stored appropriately and are suitable for use.
- The trust must ensure staff are trained and competent to administer medicines under PGDs.

Good Hope Hospital ED

- The ED at Good Hope Hospital must ensure they follow policies and procedures about managing medications; including storage, checking medications are in date, and safe disposal of medications.
- The ED must ensure that cleanliness standards are maintained throughout the department in order to ensure compliance with infection prevention and control requirements.

GHH Surgery

- The trust must consistently maintain medicines within their correct storage conditions to ensure medicines are suitable for use.

Solihull Hospital Medical Care

- The trust must ensure staffing is in line with safer staffing guidelines.

Castle Vale Dialysis

- The trust must review and improve security and access arrangements at the unit.
- The trust must review its clinical waste storage at the unit.
- The trust must ensure only clinical waste skips with working locks are accepted and used at the unit.
- The trust must review its waste audit process to ensure audits are carried out properly and are effective.

The trust SHOULD:

Trust wide

- improve its BME representation at senior management levels in the organisation.
- staffing levels did not meet the trust's agreed establishment. The trust should ensure sufficient staff (medical and nursing) in its substantive establishment to avoid the overreliance on agency staffing.
- continue to strive to meet the access standards for patients who require care and treatment.
- improve its response to complaints to meet the targets the trust has set itself.
- continue to improve its board governance process; particularly with regard to the BAF and board visibility of lower level risks.

BHH ED

- The trust should consider that patients have a pain assessment and are provided with pain relief which is timely.
- There must be effective systems to make sure that all complaints are investigated without delay.

BHH Surgery

- The trust should mitigate and action risks on the risk register by regularly reviewing the risks in a timely manner.
- The trust should consider a review of the appraisal system to ensure that they are all meaningful and that those areas with low completion rates, staff review and target.

Outstanding practice and areas for improvement

- The trust should consider having a clear system across all departments for staff to seek advice when managing patients with learning disability patients and dementia.
- The trust should review its systems of flow and management of bed capacity by managing discharge of patients in a more robust manner.
- The trust should improve sufficient staffing levels in general surgery and the trauma and orthopaedics department. The risk of low staffing on these areas has been a risk on the risk register a while now.
- The trust should ensure patients have timely access to pressure relieving equipment suitable for their needs.
- The trust should review unplanned re-admission rates to identify themes and take action to reduce.
- The trust should take steps to reduce delays in the patient journey and ensure people are able to access care and treatment in a timely way.
- The trust should take steps to improve the environment for patients who were transported to theatre through the basement corridor.
- The trust should ensure patients have access to translation services when required.
- The trust should ensure governance structures are embedded and a structured approach is taken to the identification and management of organisational risk.

BHH Critical Care

- The trust should ensure local rules for lasers are signed and in date.
- The trust should ensure service records for lasers in ophthalmology are up to date and accessible for relevant staff.
- Ensure a robust system is in place to monitor infection control in main outpatient areas including hand hygiene compliance.

BHH OPD DI

- The trust should ensure there is a robust system in place to monitor infection control and hand hygiene compliance in the main outpatient clinics.
- The trust should ensure all equipment in the outpatient department is up-to-date with electrical safety testing.

Good Hope Hospital ED:

- The ED should continue to monitor the management of complaints for Good Hope Hospital, ensuring these are investigated and managed within trust timescales.
- The ED should ensure that all appropriate patients receive a risk assessment relevant to their individual needs upon entering the department; for example falls risk assessments.
- The ED should ensure that the room used to assess patients experiencing mental health symptoms is safe and fit for purpose, and free from clutter.

GHH Surgery:

- The trust should ensure compliance with the Mental Capacity Act (2005) is documented.
- The trust should take action to improve adherence to infection prevention and control procedures

GHH Outpatients and diagnostic imaging:

- The trust should ensure local rules for lasers are signed and in date.
- The trust should ensure service records for lasers in ophthalmology are up to date and accessible for relevant staff.
- Ensure a robust system is in place to monitor infection control in main outpatient areas including hand hygiene compliance.

Solihull Hospital Surgery

- The use of the WHO surgical checklist process should improve, to prevent the risk of incorrect records.

SH Outpatients (Ophthalmology)

- Controlled medications should be managed according to the trust policy.

SH MIU

- Ensure the public in the area understand the remit and kind of service on offer via the MIU.

Castle Vale Renal Unit

- The trust should consider employing a renal psychologist to support patients' emotional needs.
- The trust should ensure its renal service participates in the British Kidney Patient Association's national patient-reported experience measure survey.

Runcorn Road Dialysis

- The trust should consider employing a renal psychologist to support patients' emotional needs.

Outstanding practice and areas for improvement

- The trust should ensure its renal service participates in the British Kidney Patient Association's national patient-reported experience measure survey.
- The trust should display all the unit's key safety performance data where patients can read it.
- The trust should ensure access to the water plant room is controlled.
- The trust should ensure patients' records are kept secure at all times.
- The trust should consider improving the environment for children in the waiting areas and treatment rooms as these were not child friendly.
- The trust should consider making more activities available for very young children to help distract them whilst waiting to be seen.

Community Services Adults

Chest Clinic

- The trust should ensure that patient comments such as excessive waiting times are recorded and reviewed to enable opportunities for improvement to be identified.
- There were delays to podiatric surgery due to a shortage of anaesthetists. The situation looked improved for planned surgery in 2017, but there were still one or two patients in May and July 2017 that would be waiting over 18 weeks for surgery.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Safe Care and Treatment - Regulation 12 2 (d), (g), (h)</p> <p>The Provider did not assess the risk of, prevent , detect and control the spread of infection including those that are healthcare related.</p> <p>Medical and Nursing staff at both Birmingham Heartlands Hospital and Good Hope Hospital in Outpatients theatres and the Emergency Department did not follow good IPC practices.</p> <p>Staff in Theatres at Good Hope Hospital were wearing their surgical theatre clothing outside of the theatre environment.</p> <p>The Emergency department at Good Hope Hospital had blood on the floor from a previous patient which was not cleaned before the cubicle was used for the next patient.</p> <p>The hospital did not collect data to determine rates of surgical site infection at Solihull Hospital.</p> <p>The three side rooms in intensive care at Birmingham Heartlands Hospital did not have negative pressure to contain any bacteria within the room to reduce the risk of cross infection to other patients. Regulation 12 (2) (h)</p> <p>The environment in ED at Birmingham Heartlands Hospital did not meet the needs of patients waiting. Having patients waiting in the corridor compromised their safety, resulted in ambulance waits and prolonged handover waits. Regulation 12(2) (d)</p>

This section is primarily information for the provider

Requirement notices

Staff did not store and manage medicines safely

In the surgical department at Birmingham Heartlands Hospital expired controlled medicines for patients were not disposed of correctly. Staff did not record fridge temperatures accurately and temperatures exceeded recommended limits. Staff supplied and administered medicines under Patient Group Directions (PGD) when they were not trained to

do so. Regulation 12 (2) (g)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Premises and Equipment 1(b), 1(c)

All premises and equipment used by the service provider must be-

(b) Secure

(c) Suitable for the purpose for which they are being used

- The premises in ED were not suitable for the service provided, including the layout and size to accommodate the potential number of people using the service at any one time.
- Security and access to the critical care unit was not sufficiently robust.
- Security and auditing of clinical waste storage did not meet required standards.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18: Staffing

18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

- Solihull Hospital Medical Care - ensure staffing numbers are sufficient to meet the needs of patients. We saw that staffing levels were not sufficient to meet the needs of patients.