Heart of England NHS Foundation Trust

Good Hope Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Not sufficient evidence to rate
Maternity and gynaecology	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We carried out this unannounced responsive inspection because the trust was in breach with regulators Monitor, and we had received intelligence which warranted our response and so we arranged the inspection. The inspection took place between 08 and 11 December 2014. We had inspected the service in November 2013 and the trust was still working through compliance action plans.

This inspection was an unannounced responsive inspection and as such we will not be rating the service. The purpose of the report is to share with the trust and the public the evidence we gathered during that inspection. It is also important to note that at the time the trust was in transition with many changes within the trust executive team, some of whom were in interim posts. This had been precipitated by the previous Chief Executive resigning in November 2014.

Our key findings were as follows:

- Widespread learning from incidents needed to be improved.
- Appraisals for staff were not widely undertaken achieving 28% compliance at the time of our inspection.
- Staffing sickness and attrition rates were impacting negatively on existing staff.
- The congestion within the hospital was having negative impacts across all the core areas we inspected. For instance the number of patients having to wait in recovery more than 30 minutes was high.
- Discharge arrangements required improvement; we saw that only 35% of patients were discharged on or before their planned date of discharge.
- The care of the deteriorating patient was generally managed well.
- Arrangements for patients with reduced cognitive function were not always effective. This meant that some patients did not receive the level of care and support they required.
- The leadership was in a transition phase with many in interim posts.
- The culture within the trust was one of uncertainty due to the number of changes which had occurred.
- Staff could not communicate the trust vision and strategy.
- Governance arrangements needed to be strengthened to ensure more effective delivery.
- IT reporting needed to be improved to ensure reporting was accurate.

We saw several areas of outstanding practice including:

- The Practice Placement team provided excellent links between the trust and the University in supporting more than 600 student nurses across all three hospital sites.
- AMU, Ambulatory Care, wards 10, 11 and 24 provided excellent local leadership, services were well organised, responsive to patients individual needs and efficient which resulted in excellent patient outcomes.

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

- Incident report feedback needs to be improved so that staff are accessing the learning opportunities.
- Appraisals need to be undertaken for staff and supervision to improve staff development.
- Arrangements for patients who required mittens were not undertaken to maintain patient's safeguards.

Importantly, the trust must:

Summary of findings

- The trust must take effective action to address the overcrowding in the majors area of the emergency department and ensure that staff on duty can see and treat patients in a timely way.
- The trust must review the operation of rapid assessment of patients to improve its consistency and effectiveness.
- The trust must take effective action to achieve consistent staff compliance of infection control procedures
- The trust must ensure all patients requiring items of restraint such as hand control padded mittens are supported with a mental capacity assessment, a DoLS and are regularly reviewed by the MDT which is recorded in the patient's notes and mittens are replaced when soiled. A consistent practice must be adopted across the trust.
- The trust must provide sufficient staff to operate the second obstetrics theatre at night, and prevent delays occurring.
- The hospital must improve the information available to outpatients departments to ensure that these are monitored and action taken to improve services through audit, trending and learning.

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

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Systems were in place for staff to report incidents and to support staff to learn from incidents but we found contradictory views among staff about the impact that incident reporting had on improving services. A system of rapid assessment of patients had been put in place since our last inspection but this needed further work to be consistently effective in reducing risk. Staffing levels had improved since our last inspection but some patients with complex needs such as mental ill-health were not getting the extra support they needed to keep them safe when the department was very busy. The ED department was under considerable pressure. A streaming system helped to promote the flow of patients through the department and improved access to the services. The trust was trying further ways to reduce some of the pressure such as commissioning a GP service to work within the ED. New arrangements put in place to rapidly assess patients when they arrived were patchy in their application and needed greater oversight. There were management systems in place to keep the department flowing when it was very busy and avoid the risks associated with overcrowding but many target times were not being met. Senior nurses did not have confidence in the trusts escalation policy for the ED department. Local leadership was effective and encouraged innovation, local leaders were visible but there was no evidence of a strategy or vision for this service. Skill and competency levels were used effectively and team work was good. Nursing and medical staff felt supported by their managers. Risk was managed locally by a

Summary of findings

system of real time data generated. This measured performance against key target points of responses to patients when they attended the department. However the trust wide risk register was used to little effect to support the problems faced by the ED at risk of being overwhelmed by the number of patients attending.
Staff across roles and at different levels expressed no clear understanding of the value of learning from patient's complaints. Some public engagement methods had been attempted at a local level but appeared to have fallen into disuse.

Medical care

Requires improvement

Medical services at Good Hope Hospital required improvement despite the fact that care was delivered by compassionate and dedicated staff.
Incident feedback for staff was poor and safety thermometer incidents had steadily increased over the last three months. Staff had not attended all mandatory training. Completion of risks assessments and responding to patient risks required improvement across some medical wards. Nurse staffing levels and appropriate skill mix was problematic across some medical wards and the ability to safely discharge patients in a timely manner was a concern. Staff did not feel involved in decisions about the wards they worked in. Local level leadership was supportive and nurturing particularly on AMU, Ambulatory Care, and wards 10, 11 and 24. However communication and support from senior management and the executive team was described as; unsupportive and aggressive.

Surgery

Not sufficient evidence to rate

Following a never event, meetings were held with staff to discuss lessons learnt and new procedures to prevent re-occurrence. The basement corridor used to transfer patients to theatres was in a state of disrepair. The World Health Organisation (WHO) five steps to safer

Summary of findings

surgery checklist was not always done in the anaesthetic room, data was input later due to IPAD connection problems which could lead to errors.
There were 62 surgical cancellations in all theatres for trauma and orthopaedics between 1/9/14 and 9/12/14. Data from the trust showed that the Vanguard theatre session times use averaged 73.6%. The main theatres averaged 86.43% against a trust target of greater than 90% usage.
Patients perceived staff shortages in some of the surgical wards and several patients reported having to wait a long time for call bells to be responded to.
Staff expressed concerns in relation to challenging senior management about significant issues relating to clinical safety. Staff felt that when attempting to support and speak in favour of their patients they were perceived as obstructive and negative for raising concerns. Staff described an 'Enhanced Recovery Pathway' for orthopaedic patients as an example of implementing national best practice.

Maternity and gynaecology

Requires improvement

Incident reporting was good and staff told us they had opportunities to learn from issues raised. There were no safer staffing information on display for staff, women and visitors to the maternity unit. The percentage of women having interventional births was higher (worse) than the England average.
Some good initiatives were observed to facilitate efficient and safe admission and discharge, however support for low risk mothers and assistance with breast feeding was minimal. The caesarean section and induction of Labour rates were significantly higher than the national average.
There was some tension between Labour ward and Maternity Assessment Unit staff, regarding admission criteria for women.

Summary of findings

			The Maternity department at Good Hope Hospital lacked visible leadership and the staff were unclear about the maternity strategy and felt powerless to affect service development and delivery. Staff worked well in their teams, but there was little inter-department co-operation, and some staff told us they worked in a 'blame culture' which lead them to practicing defensively.
Outpatients and diagnostic imaging	**Requires improvement**		The outpatients department at Good Hope Hospital required improvements to be made in order that safety and the responsiveness to the needs of patients improved. Incident reporting was poor as was the feedback process from any investigation of incidents to staff. This meant that the department could not learn and improve services. Infection control processes required improvement as staff did not adhere to trust policies in this area. Performance data which would have assisted the department to develop and improve was not available to senior staff and therefore the team were unaware of issues requiring action. The leadership of the department was felt by staff to require improvement as action had not been taken to address identified issues. The diagnostic departments functioned well and were safe and responsive to patient's needs. Despite national shortage in radiology staff the department was led by leaders who supported staff and championed improvements to services. Processes within these departments were in place to ensure that they were safe and responded to the changing needs of the patients and services within the hospital.

Good Hope Hospital

Detailed findings

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

Detailed findings

Contents

Background to Good Hope Hospital

Good Hope Hospital is an acute hospital, serving a population of approximately 450,000. It is the second largest of the three hospital locations run by the Heart of England NHS Foundation Trust. It provides general and specialist hospital and community care for the people of East Birmingham, Sutton Coldfield, Tamworth and South Staffordshire. Good Hope Hospital has approximately 357 beds and is a centre for pain management.

Trustwide information.

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

This trust is a Foundation Trust which means it is a not-for-profit, public benefit corporation. It is part of the NHS and provide over half of all NHS hospital, mental health and ambulance services. NHS foundation trusts were created to devolve decision making from central government to local organisations and communities.

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

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

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper

Inspection Manager: Donna Sammons

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

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

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

Detailed findings

How we carried out this inspection

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

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

Are services safe?

Are services responsive to patient's needs?

Are services well led?

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

- Emergency Department (A&E)
- Medicine
- Maternity
- Outpatients and diagnostic imaging.

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

Facts and data about Good Hope Hospital

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

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

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

Good Hope Hospital emergency department (ED) serves the generally affluent outer city Birmingham suburb of Sutton Coldfield and the more economically deprived areas of east Birmingham. During 2013/14 it had 79,453 attendances at its emergency department and covered 22,283 emergency admission spells. The department was refurbished in 2013.

We visited the hospital ED unannounced on 10 December 2014, spoke with 11 patients and relatives and 17 staff in a range of roles including nursing and medical managers. We observed the care provided to patient's and looked at records.

This visit was undertaken to follow up on a number of concerns that we were aware of and requirements we made for improvement at our last inspection of the hospital in November 2013 and updated in January 2014. We were concerned that patients were waiting longer than expected to receive treatment. During our inspection in 2013 we found the emergency department was very busy, people who walked in were not being assessed by trained staff and this was a risk to their health and safety. People's privacy and dignity were not always respected and care was delayed because of shortages of staff within the department.

At our inspection on 27 February 2014 we found that the process for assessing patients had been reviewed and this resulted in an assessment of their need by a clinical person within the recommended 15 minutes of arrival. We also found that care needs were being met by staff whilst they waited for treatment.

Urgent and emergency services

Summary of findings

Systems were in place for staff to report incidents and to support staff to learn from incidents but we found contradictory views among staff about the impact that incident reporting had on improving services. A system of rapid assessment of patients had been put in place since our last inspection but this needed further work to be consistently effective in reducing risk. Staffing levels had improved since our last inspection but some patients with complex needs such as mental ill-health were not getting the extra support they needed to keep them safe when the department was very busy.

The ED department was under considerable pressure. A streaming system helped to promote the flow of patients through the department and improved access to the services. The trust was trying further ways to reduce some of the pressure such as commissioning a GP service to work within the ED. New arrangements put in place to rapidly assess patients when they arrived were patchy in their application and needed greater oversight. There were management systems in place to keep the department flowing when it was very busy and avoid the risks associated with overcrowding but many target times were not being met. Senior nurses did not have confidence in the trusts escalation policy for the ED department.

Local leadership was effective and encouraged innovation, local leaders were visible but there was no evidence of a strategy or vision for this service. Skill and competency levels were used effectively and team work was good. Nursing and medical staff felt supported by their managers. Risk was managed locally by a system of real time data generated. This measured performance against key target points of responses to patients when they attended the department. However the trust wide risk register was used to little effect to support the problems faced by the ED at risk of being overwhelmed by the number of patients attending.

Staff across roles and at different levels expressed no clear understanding of the value of learning from patient's complaints. Some public engagement methods had been attempted at a local level but appeared to have fallen into disuse.

Are urgent and emergency services safe?

Requires improvement

Summary

Staff at all levels had access to the incident reporting electronic system and understood their responsibility to report incidents. A system had been devised to support staff to learn from incidents and risk issues but we found this was not always comprehensive or timely containing contradictory views among staff about the impact that incident reporting had on improving services.

Hygiene and control of infection was generally good but there was room for further improvement.

The emergency department at was refurbished in 2013 and it was a large well organised space and also a self-contained paediatric emergency department.

Patient records were generally fully completed but there was room for greater scrutiny of medicines storage.

There were systems in place to safeguard vulnerable adults and children and staff within different roles understood their responsibility.

A rapid assessment process operated with an aim to assess every patient within 15 minutes of arriving. This process was still being worked up to effectiveness in the very busy major's stream in the department and was working well in paediatrics. The National Early Warning Score (NEWS) system to pick up deterioration in a patient's condition was in place but not consistently used while patients were waiting. A system for collecting a range of care indicator metrics had been set up across all three hospital sites to develop a risk assessment approach. In the minor's stream at Good Hope Hospital patients with high risk injuries were called back for a clinic that was held three times each week.

Although we noted no issues with the levels of nursing or medical staff at the time of our visit, there were periods where the skill mix was inappropriate. Patients with complex needs such as mental ill-health would have benefited from extra support to keep them safe while they waited for transfers or admission.

Urgent and emergency services

Incidents

- This was an unannounced inspection so we did not ask the trust in advance to share information with us. The emergency directorate clinical director across all three hospital sites told us that there had been two recent incidents requiring investigation; moving a patient from a resuscitation bed in order to deal with an in-house cardiac arrest and a cerebral haemorrhage that was missed by medical staff.
- The trust used the an electronic system for reporting incidents. Staff at all levels we spoke with told us they had access to this and understood their responsibility to report incidents, although some middle grade doctors were unsure of how to do it.
- We found contradictory views among staff about the impact of incident reporting.
- The clinical director for the emergency department across all three hospital sites said that the reporting system was cumbersome and the directorate 'probably under reported'
- The consultant risk lead for the directorate across all three hospital sites said that the reporting culture was good, and matrons looked at and evaluated reported incidents on a daily basis. They acknowledged that getting information back to staff who reported incidents was a weakness in the system.
- Local nursing leaders at Good Hope Hospital told us that incident reporting was good in the department.
- The trust had responded to our concerns earlier in 2014 about learning from incidents. The emergency department trust wide action plan included devising and distributing a monthly bulletin for all staff called 'Risky Business'. This was written by the consultant lead on risk for the directorate across all three hospital sites.
- We noted that learning about headache from the missed cerebral haemorrhage incident that required investigation, appeared in a 'risky business' bulletin. Some medical staff referred to this publication when we spoke with them and said it was useful.
- Another publication called "ED Pearls" was distributed to doctors in the directorate. The risk lead consultant told us that these dealt with issues that arose from clinical incidents and the directorate then mapped these in with education and teaching. We saw an example of this on headache.
- The consultant risk lead for the ED directorate also produced regular handover quality topics bulletins but staff did not refer to these when we spoke with them.
- Staff across a range of roles they said that they got no feedback from reporting an incident and there were no formal arrangements for learning from incidents.
- A system for collecting a range of care indicator metrics had been set up within the directorate across all three hospital sites. These metrics/ quality markers were to provide assurance supporting a regular process and develop a risk assessment approach. At Good Hope Hospital ED leaders told us nursing teams peer reviewed their data for objective assessment of performance.
- The clinical director across all three hospital sites told us that the department conducted incident reviews and now included the case for mortality and morbidity. They gave an example of one review held during the week before our visit as a result of a cardiac arrest in the department.

Cleanliness, infection control and hygiene

- The emergency department was clean and tidy.
- There were hand wash gel dispensers on walls at regular intervals around the department and also in the waiting area and supplies of personal protective clothing in all clinical areas for staff to use.
- We saw staff cleansing their hands routinely as they moved around the department.
- Nursing staff were 'bare below the elbow' in keeping with the trust policy but we noticed that a number of consultants were not. Some of these may have come from outside of the department for consultations.
- We observed that there was a problem with management of disposal of clinical waste (orange bags) in the hospital as they were not all being securely contained while waiting for disposal.
- Not all equipment was cleaned effectively after use. We noted that blood spots were left on a trolley by a junior doctor and there were blood smears on the blood gas machine.

Environment and equipment

- The emergency department at Good Hope Hospital was refurbished in 2013. It was a large well organised space although ambulance queuing meant that the automatic doors near the handover station were open to the weather for much of the time.
- There was a self-contained paediatric emergency department with its own triage room, four isolation cubicles and kitchen. The paediatric resuscitation space was in the general resuscitation room but directly opposite the paediatric department door.

- The area where patients waited for transfers or transport home was beside the exit doors and this meant that confused patients could leave unaccompanied without being noticed by staff.
- The resuscitation room had four adult bays, contained a good range and standard of appropriate equipment and supplies. There was a relative's room with direct access to a viewing room.

Medicines

- The trust had procedures for the safe storage and administration of medicines.
- We found that some medicines in storage were out of date. One box of medication was left out and unattended in the paediatrics department. We brought this to the attention of the nurse in charge.
- We observed a porter managing the oxygen supply to a patient. Porters confirmed this was routine when nurses were very busy although porters were given no training in this procedure.

Records

- We looked at 21 sets of patient's records. They were generally fully completed.

Safeguarding

- Staff that we spoke within different roles understood their responsibility for safeguarding children and vulnerable adults and told us they had received training.
- The matron was the safeguarding lead for the ED department and had recently undertaken level 3 safeguarding training.
- The ED department across all three hospital sites reported in its November 2014 addition of Risky Business a significant increase in enquiries about children at home (the invisible child) by ED staff treating adults with mental health issues, alcohol and drug misuse between 2013 and 2014.
- The prompt for safeguarding consideration was ticked as done on the records for all of the of the ten paediatric patients at Good Hope Hospital ED department that we looked at.

Assessing and responding to patient risk

- When we arrived at 8.45am there no patients in the general waiting area of the emergency department. In the major's area however, there were patients waiting on trollies and chairs in the corridors, all of the treatment bays were occupied and the department was busy but calm and organised.
- When patients booked in at reception they were streamed for paediatric, major or minor injuries/ conditions and their details logged on an electronic system.
- The majors area had three cubicles dedicated only to assessment of patients and nursing leaders told us this was maintained even at times of high flow.
- A rapid assessment process operated with an aim to nurse assess every patient within 15 minutes of arriving. Nursing leaders told us, 30 minutes was key for safety and beyond that time the risk in the department was escalated. Data produced by the trust showed that for the period 3 to 16 November 2014 the 15 minute target had been achieved on only three out of the 13 days.
- A nursing leader told us that the rapid assessment process had however improved performance against the target time of seeing a clinician within 60 minutes. Data produced by the trust for the same period showed the 60 minutes target had been reached on nine out of the 13 days.
- One doctor told us that triage arrangements were "chaotic" and they were not clear on the exact process since the new system was put in place two months previously.
- Parents we spoke with in the paediatrics emergency area said they were very pleased with the speed at which their children had been seen.
- However in adult majors stream we noted a very frail elderly person, referred by their GP had been assessed by a nurse and seen by a doctor but was waiting in the corridor for over two hours to be seen by a medical specialist physician. Tests were being run during that time. The patient, who was at risk from pressure ulcers, was curled asleep on a hospital mobile chair under a blanket as no trolley had been available when the nurse assessed the patient. A trolley was available by the time we enquired but no one had monitored this situation in order to get the patient moved onto a safer surface to support their skin as soon as was possible.
- An elderly person with mental ill-health had been waiting for over five hours for RAID intervention to find a bed in a psychiatric unit. The waiting area was beside the exit doors and there were no staff available to check on or support them regularly although they had been offered food and drink. They became increasingly

agitated and confused and left the department on one occasion unnoticed. Senior nursing staff had to escalate this through their operations manager to get a direct call to the psychiatric services bed manager 'to make sure the patient didn't get forgotten'.

- A care indicator metrics system was in place in the majors area of the department to provide assurance supporting a regular process across the directorate and develop a risk assessment approach. These metrics included patient observations called the National Early Warning Score (NEWS) to pick up deterioration in a patient's condition.
- We looked at a sample of 11 adult patient records on the day of our visit. Out of the 10 for whom it was appropriate, only five had recorded NEWS scores on arrival at the department and only one patient had the assessment repeated after an hour as it should have been. A pain score was recorded for seven out of the 11 patients.
- Three out of 10 paediatric records showed no PEWS score or indication that an assessment was not appropriate. Two assessments had not been repeated after one hour. All 10 children had a pain score recorded.
- At 11.35 on the day of our visit there were five ambulances waiting to handover patients and the majors area was full. We asked nursing leaders what escalation had happened and they told us that the site team were aware but no action had been noticed by ED staff at that point. Site managers agreed the situation was challenging but the management/operations team had not yet been in the ED that morning. Also that one management/operations meeting in recent weeks had led to contact with the local Clinical Commissioning Group.
- In the minors streamed patients with high risk injuries were called back for a clinic that was held three times each week.

Nursing staffing

- The paediatrics emergency department closed for three hours over a 24 hour period and was open from 7am to 3am daily and the lead nurse was included in the overall complement for the whole department. All band six and seven nurses had paediatric competency and adult services staff rotated through paediatrics. There was a play specialist for 12 hours each day.
- Senior nurses confirmed that that there had been staffing changes since our last inspection in November 2013. There were currently no vacancies except for one band 6 nurse and the interviews were being held the following day.
- There had been an issue of specialist nurses being 'poached' by recruitment agencies and the boards response was to agree an uplift in hourly pay for bank staff already employed by the trust. This resulted in gaps for leave or sickness being filled mostly by the departments own staff.
- The matron, two senior sisters and one sister leading teams were on duty.
- There were 12 qualified nurses on duty for the early shift and 13 rostered for the late shift including paediatrics although 11 were planned. The extra nurse was in response support to a number patient's waiting for admission to medical beds.
- Nurse leaders told us as there were a number of trollies with patient's waiting in the corridor an extra capacity nurse was allocated to look after them. A faculty nurse worked on the roster and that additional help could be triggered if needed as had been the case in the week before our inspection.
- There were enough nursing staff within the space available to treat patients.
- There were also three health care assistants on duty as per the roster on the early shift with three rostered for the late shift. We noted that at least two patients with complex needs would have benefited from extra support in the early shift but no one was made available to provide it until we raised the issue.
- The staffing in the clinical decisions unit was one staff nurse and one health care assistant for four bedded patients and patients in the seated area waiting for investigations but not needing a bed.
- We noted the one housekeeper for the department on duty and were told they worked week days only.
- Handovers at the staff of each shift included trust wide information update, 'hot topics' and incidents if they had led to a change in policy. There was a bedside handover for patients waiting for admission.

Medical staffing

- The minors flow was staffed and led by Advanced Nurse Practitioners (ANP) who worked across three shifts a day. There was some shortfall in numbers but this could be filled with doctors.

Urgent and emergency services

- Newly qualified nursing staff told us that all the doctors were very responsive to being called for advice or bleeped to attend.
- Nurse managers told us there was 'an excellent relationship' between consultants and nurses. We observed good team working relationships.
- There were some gaps for middle grade doctors and the trust was trying to improve the attraction of these posts.
- Consultants worked across all three hospital sites and the clinical lead for the ED directorate was working at Good Hope Hospital on the day of our visit. There was an early, middle of the day and late until 10pm, on call shift with one consultant on each shift.
- Good Hope ED had its own clinical lead and staff told us they were highly visible on site. Other consultants rotated through the other two hospitals.
- The lead ACP (a consultant nurse) for the ED sat on the medical roster.

Major incident awareness and training

- There were supplies of major incident equipment, written protocols and staff jackets which identified specific roles, easily available and neatly organised on clear display in the department.
- Staff told us that major incident training is undertaken annually across the emergency services directorate and the three hospital sites.

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

Requires improvement

Summary

A streaming system helped to promote the flow of patients through the department and improved access to the services. The trust had recently commissioned a GP service to work within ED to see patients who arrived at the ED instead of seeing their own GP. Children had a self-contained ED, which was staffed and open for 19 hours each day. The minor's area was open until midnight and operated a see and treat service.

The major's department was very busy and not meeting national targets to see, treat and discharge or admit patients within four hours of arriving. Target times for ambulance handover and access to a clinician were often not met. However there were management systems in place to keep it flowing. New arrangements in place to rapidly assess patients when they arrived were patchy in their application and needed greater oversight. Patients with complex needs such as mental ill health or at risk of pressure ulcers did not always get the level of support they needed while they waited. The GP referral pathway into the acute medical unit (AMU) wasn't functioning effectively as it was overloaded.

Although there were some arrangements for escalating the risk of overcrowding senior nurses expressed no confidence in the escalation policy.

Staff across roles and at different levels expressed no clear understanding of the value of learning from patient's complaints.

Service planning and delivery to meet the needs of local people

- There was a streaming system to promote the flow of patients through the department and improve access to the services. These streams were minor injuries (minors), major injury and trauma (major's), paediatrics (children's) and the clinical decisions unit (CDU).
- Local nurse leaders told us the trust was intending to trial 'fragility beds' within ward 21 in the new building.
- The paediatrics ED was open from 7am to 3am daily. Outside of this time children had to be seen in the adult's areas. However there is a paediatric emergency team on site for paediatric emergencies.
- There was a REACT team operating within the department to ensure patient's had support from allied health professionals such as occupational and physiotherapists when discharged.
- The ED minor's service held regular review clinics for high risk minor ailments, led by a consultant.
- The trust had recently commissioned a GP service to work within ED. Staff told us that on one recent day the GP service had seen 35 patients who arrived at the ED.

Meeting people's individual needs

- We noted staff in the department were kind but too busy to keep track of the needs of some patients. These were patients with complex needs including frailty and mental ill health that were waiting for specialist assessment, admission to a ward or waiting to be transferred to other services.

Urgent and emergency services

- Senior nurses told us that there was a GP referral pathway into the acute medical unit (AMU) but it wasn't functioning effectively as it was overloaded. At weekends the system got completely jammed.
- There was no information or guidance on display about using the department in any of the waiting areas except a small leaflet written in English.
- Staff told us that they used a telephone translation service and this worked well when seeing patients.
- There was no specific pathway in place to support patients with learning disability or living with dementia and enable staff to identify them and respond appropriately to their specific needs while they waited in the department.

Access and flow

- An Ambulatory Emergency Care Unit (AECU) was provided to help prevent medical patients such as an older person with mobility issues having an unnecessary overnight stay in hospital. There were four clinical rooms in the unit, patients either came through from the ED, having potentially been referred through the Rapid Assessment Team, or were GP referred direct.
- Waiting times were not displayed in the main waiting area to provide information to patients and relatives.
- The minor's area was open until midnight, it operated a see and treat service and was staffed and led by Advanced Nurse Practitioners (ANP) who worked across all three hospital sites.
- The clinical decisions unit had four beds in two cubicles.
- The paediatric emergency department was closed between 3am and 8am when children were seen through the adult's areas. The children's waiting area was only used during the daytime.
- The majors area had 24 cubicles, four of which were used for ambulance handover only.
- At the time of our visit the department was on an escalation risk level of three to four
- Seven patients had spent over 10 hours in the ED and four had spent over 12 hours there. These patients were waiting to be admitted to wards.
- Later on the day of our visit at 4pm, staff told us there were seven 12 hour breaches of the national target to see, treat and admit or discharge patients within 4 hours of attending.
- The department was flowing however. At 9 am senior nursing staff told us their priority at that time was to create space in the resuscitation bay. This was done within 10 minutes in time for another patient who needed it.
- At 2.45 pm there were eight patients in trollies and chairs waiting in the corridors. At 3.15 there were four patients in trollies and chairs waiting in the corridors.
- The trust's metrics showed the emergency department at Good Hope Hospital had missed its target for assessing patients within 15 minutes of arriving each day on 10 days from 5 November 2014 to 16 November 2014. Patients had been assessed within 30 minutes of arriving on eight of those days.
- For the same period, the target of one hour from time to arrival to seeing a clinician was not met on four of the 13 days. Most patients were seen within 67 minutes but on one Monday the average time was one hour and twenty minutes.
- From 5 November 2014 to 16 November 2014 the department had missed the national target for seeing, treating and discharging 95% of patients within four hours of arriving, for eight out of the 13 days. On two days it fell below 90%.
- On five days during the same period more than three patients, waiting to be admitted to wards or discharged waited over eight hours in Good Hope Hospital ED from the time of arrival. On one of those days it was 17 patients.
- For four days during the same period, six or more patients waited over 30 minutes to be handed over by ambulance staff, on one of those days it was 10 patients. During that period only one patient waited for over 60 minutes.
- We observed an efficient ambulance handover and booking in system with good communication between hospital staff and paramedics.
- Senior nurses expressed no confidence in the escalation policy, 'actions don't happen and the escalation policy doesn't take into account the flow problem'; 'when a level four alert is triggered it's too late, you are broken for the next 48 hours, it's not a system that effectively alerts other agencies to accommodate and compensate. A hospital ambulance liaison officer (HALO) is put in but this should all be flagged up much earlier. We have roles that will speak to Silver Command if capacity rises consistently; we have regular huddles to

discuss how to make a resuscitation bed available for example if someone else is on the way. The overall view is to make sure every patient is in the best place in the department for safety'.

Learning from complaints and concerns

- We found that staff across roles and at different levels expressed no clear understanding of the value of learning from patient's complaints. For example a doctor told us they were not aware if the ED had received any complaints in recent months; a nurse told us that complaints themes were mentioned in handover briefings 'but the department doesn't learn from them; often complaints are about individuals but there is no change despite the complaint'.

Are urgent and emergency services well-led?

Requires improvement

Summary

We heard no evidence of a strategy or vision for this service. Risk was managed by a system of real time data generated to measure performance against key target points of response to patients when they attended the department. 'Impact of extended stay in ED' was ranked as a high risk on the ED directorate and trust wide risk register. However the trust used the ED directorate's risk register to little effect as staff expressed no confidence in the effectiveness of the escalation policy and we saw no credible tool for it.

Local leadership appeared to be strong and local leaders including the clinical lead were visible. Staff were doing their best to provide care and treatment under difficult conditions and to keep the flow at least moving to avoid the risks associated with overcrowding.

Skill and competency levels were used effectively in creating specific staff roles within the streaming system to reduce pressure in the ED, to manage teams of nurses and to contribute to the medical roster. Staff felt supported by their managers.

Staff at all levels and in all roles were generally positive about their work and the department and innovative ways had been found to ensure that local staff filled gaps in the roster created by leave and sickness and felt valued for doing so.

Staff across roles and at different levels expressed no clear understanding of the value of learning from patient's complaints. Some public engagement methods had been attempted at a local level but appeared to have fallen into disuse.

Vision and strategy for this service

- We heard no evidence of a strategy or vision for this service. However staff were focused on their roles and patient outcomes.

Governance, risk management and quality measurement

- The emergency directorate trust wide generated real time data to measure performance against key target points of response to patients when they attended the department. These included ambulance handover time, time to assessment, time to treatment and the length of time patients waited in the department.
- The emergency directorate had a risk register across all three hospital sites. However there was no updated review of this situation on the register which stated 'review in 2013'.
- The risk lead for the directorate across all three hospital sites told us that it had been reviewed and this risk was also on the trust risk register and not regarded as an emergency department risk alone.
- In response to safety concerns expressed by the emergency department directorate, we noted the trust had developed a Standard Operating Procedure for emergency department escalation trust wide at all three hospital sites. This was due to be introduced operationally on 9 December 2014. It relied on data collected hourly by a band 7 nurse and inputted to the emergency department matrix.
- A system for collecting a range of care indicator metrics at the ED had been set up within the directorate to manage risk.
- Staff felt that despite escalating issues on the ED risk register, it did not seem to make a difference and resolve the risks within it.

Urgent and emergency services

Leadership of service

- The emergency directorate shared consultants and advanced nurse practitioners across three hospital sites. There was a clinical lead for each hospital and the clinical director was responsible for all three sites. There was a matron at Good Hope Hospital emergency department.
- We noted that staff were doing their best to provide care and treatment under difficult conditions and to keep the flow at least moving to avoid the risks associated with overcrowding.
- Local leadership appeared to be strong and local leaders including the clinical lead were visible. Senior nursing staff were constantly managing how cubicles across different parts of the department could be used and the specialist skills available on duty. It was the role of senior sisters and matron to co-ordinate and make decisions supported by consultants and the clinical lead.
- All staff at Good Hope Hospital ED were occupied despite lack availability of space to treat so many patients.
- Band seven nurses led a team; they understood their specific role and had a good grip on the boundaries of their influence.
- The paediatrics ED was well led with a play therapy service well integrated into caring for the children.
- Advanced nurse practitioners and consultants working in the minors flow appreciated the benefit of working across hospital sites.
- A rapid assessment team meant that staff were engaged in the planning process of patient care. However the effectiveness of outcomes from rapid assessment needed greater monitoring and evaluation of effectiveness. As initial feedback from staff indicated it was not working as planned.
- Senior nurses and medical staff expressed no confidence in the effectiveness of the escalation policy and we saw no credible tool for it when we observed an operations meeting.
- Operationally local nursing and medical leaders were not effectively supported under the pressure experienced by the ED.

Culture within the service

- Staff at all levels and in all roles were generally positive about their work and the department. They were all aware however that they were constantly working hard against the risks associated with overcrowding.
- The uplift in hourly rate for department staff covering 'bank' shifts had made them feel better valued by the trust.

Public and staff engagement

- A large board poster display in the main waiting area of the department communicated to patients that the department had responded to their concerns about overcrowding by developing a rapid assessment team. There was a large poster in the hospital café inviting people to 'tell us what you think about our services' and explaining the various methods available to do so.
- We found that staff across roles and at different levels expressed no clear understanding of the value of learning from patient's complaints. The 'You said, We did' display boards that the trust had provided around the ED to engage with patients had fallen into disuse.

Innovation, improvement and sustainability

- Medical staff told us they received good supervision and appraisal and senior nurses had monthly one to one meetings with the matron.
- Local nursing leaders had successfully developed a closed face book internet page as a means for quickly addressing any gaps in the roster. It listed the available shifts over the coming 10 days and staff could fill them.

Medical care (including older people's care)

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

Information about the service

There are 9 medical wards with four additional wards providing medical care as the second speciality.

We inspected Good Hope medical care services on 10 December 2014 and visited medical care wards and also wards where patients with medical care needs were staying; wards AMU (acute medical unit), Ambulatory Care, 8, 9, 10, 11, 12 and 24 Hyper Acute Stroke ward.

We talked to 38 patients including some of their relatives and 55 staff to include: health care assistants, nurses, senior ward sisters, ward managers, senior managers, medics and consultants.

Summary of findings

Medical services at Good Hope Hospital required further improvements despite the fact that care was delivered by compassionate and dedicated staff.

Incident feedback for staff was poor and safety thermometer incidents had steadily increased over the last three months. Staff had not attended all mandatory training.

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

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

Local level leadership was supportive and nurturing particularly on AMU, Ambulatory Care, and wards 10, 11 and 24. However communication and support from senior management and the executive team was described as; unsupportive and aggressive.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Summary

Medical services at Good Hope Hospital were safe but required improvement. Staff reported incidents but received limited feedback to learn from lessons.

An increase in incidents in three out of four safety thermometer audits over the last three months meant patients safety was an issue. Infection control across medical wards was satisfactory. However, completion of documentation and responding to patient risks was a concern. Staffing levels across medical wards was safe, but heavily supported by bank and agency staff who were not always familiar with operation of the wards and individual patient needs.

Incidents

- There were systems for reporting actual and near miss incidents across the medicine division.
- Staff reported patient related incidents, however they did not report staffing issues for two reasons: firstly because staff found reporting staffing level concerns particularly difficult as the incident reporting system options were not straightforward. Secondly, staff told us they had no faith in incident feedback from managers and reporting staffing incidents made little or no difference.
- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There had been no (zero) reported never events within the last 12 months across medical wards.
- Opportunities to learn from incidents and obtaining feedback from senior colleagues did not occur, nurses told us they did not have the time and senior management did not make this a priority.
- Risk assessments for falls, pressure ulcers, manual handling and nutrition were completed on admission, regularly updated and care plans drawn up to reflect patient needs.
- The Trust monitored its mortality rate on a monthly basis using the Hospital Standardised Mortality Rate (HSMR) available from Dr Foster and on a quarterly basis using the Summary Hospital Level Mortality.
- Doctors told us mortality reviews were carried out monthly without nursing input. Doctor's felt nursing input would make the review more meaningful, but nurses were too busy to be involved.

Safety thermometer

- Results of the safety thermometer were displayed on every ward and area we visited to include pressure ulcers, falls, VTE (venous thromboembolism) and CAUTI (catheter acquired urinary tract infections). The results related to that individual ward or area and showed comparison with results for the previous month.
- New reported avoidable pressure ulcers for ward 24 was zero since October 2013 and the same ward reported one fall with injury since July 2014. Ward 8 showed an increase in avoidable pressure ulcers from September 2014. Falls with injury incidents had decreased between July and August then increased from September 2014. The AMU reported a decrease in both avoidable pressure ulcers and falls with injury from August 2014. VTE's had generally stabilised across medical wards since August 2014.

Cleanliness, infection control and hygiene

- All staff were aware of current infection prevention and control guidelines. There were sufficient hand wash sinks, hand gel, towel and soap dispensers across all medical wards.
- We observed staff consistently following hand hygiene practice and 'bare below the elbow' guidance. Aprons and gloves were readily available in all areas.
- Side rooms were used where possible as isolation rooms for patients identified as an increased infection control risk (for example patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.
- All wards carried out a monthly audit which looked at infection control procedures such as commode cleanliness. Results were displayed within ward corridors and we saw action plans in place for wards who had not met the standard.
- Cleaning schedules had been completed as required and housekeeping staff told us that there were sufficient supplies of cleaning materials available to use.

- Cleaning store rooms were clean and tidy and we noted that Control of Substances Hazardous to Health (COSHH) information sheets for cleaning materials were available for staff to refer to.

Environment and equipment

- Resuscitation equipment had been checked regularly, equipment was in date, appropriately packaged and ready for use.
- Pressure relieving mattresses for people at risk of pressure damage was in place. The trust had a central equipment bank for pressure relieving equipment and an effective process for issuing, returning and cleaning the equipment.
- Adequate supply of equipment to meet patient's needs across all medical wards.
- Equipment was clean, well maintained with good service history.
- Ward environment for ward 24 (Hyper acute stroke) was particularly welcoming, spacious and well laid out. Side rooms had larger than average ensuite facilities and bays of four beds had extended bed space to accommodate regular use of hoists.

Medicines

- All wards had appropriate storage facilities for medicines, and safe systems for the handling and disposal of medicines.
- The trust had a pharmacist as controlled drugs (CD) accountable officer.
- Most ward staff reported a good service from the pharmacy team except ward 8 who reported frequent delays in obtaining patient's discharged medication. Often patients were discharged home without their medication. Arrangements were made for taxis to deliver medication to the patient's home or for relatives to return to collect later that evening. This was recognised by staff as poor practice but unavoidable.
- One patient who was discharged at 2.30pm the day before the inspection waited with their family until 8pm for their medication.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient. Regular check of controlled drugs balances were recorded.
- Staff said they had had relevant training, and that their competencies for medicine administration were assessed regularly.
- Fridge temperatures were regularly checked, recorded and adjusted as appropriate. However, we found no evidence that temperatures within medication storage rooms were checked.
- Nurses wore red tabards when administering medication, in accordance with trust procedures.
- Nurses and doctors had achieved 100% in medicine management training.

Records

- Patient records included a range of risk assessments to include: manual handling, falls, nutrition and pressure ulcer damage with associated care plans. Risk assessments were completed and reviewed weekly.
- On ward 9 fluid balance charts and VIP (visual infusion phlebitis) scores were not completed for all patients.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) paperwork was completed accurately and appropriately where indicated. There was evidence that decisions had been discussed with patients and their relatives.
- We saw comprehensive and well documented wound management plans. These showed wounds were assessed; treatment records were in place evaluated to show progress of healing.
- In most areas records were not stored securely; there were instances where patient records were stored in unlocked trolleys at nurse's stations. This increased the potential for patient confidentiality to be breached.
- Documentation relating to the decision, review and care of patients using hand control padded mittens was not robust, for example, multidisciplinary review meetings had not been recorded for all patients requiring continued use of mittens.
- Dementia scores were not always in place for people who were thought to have dementia but yet diagnosed, one junior doctor on ward 10 had assessed a patient and recorded "Obviously always confused".

Safeguarding

- Staff were aware of the trust safeguarding policy; the processes involved when raising an alert and received training on induction and at three yearly intervals.

Medical staff achieved 98% attendance against the trust's 85% target for Safeguarding adults (basic awareness) level 1, and met the target of 85% for safeguarding (enhanced awareness) level 2.

- Staff knew the name of the trust safeguarding lead, were well supported and told us they would seek advice if they had safeguarding concerns.
- Safeguarding alerts were completed within the recommended 24 hour timeframe and alerts were relayed verbally during staff handover times to ensure all staff were aware of patient's safeguarding issues.
- One patient on ward 24 had been assessed as requiring hand control padded mittens to reduce the risk of the patient pulling out their NG (nasogastric tube) and self-harming. This is considered as a form of restraint and can be in the best interest of the patient.
- However, the patient had not been supported with a mental capacity assessment which could result in a DoLS (deprivation of liberty of safeguard) request.
- There was an inconsistent and relaxed approach to the care and management of hand control padded mittens across Heartlands and Good Hope hospital sites.

Mandatory training

- Ward sisters from all wards told us staff attendance to mandatory training was an area for improvement, we saw this was an issue across all three hospital sites. The trust's target for mandatory training attendance was 85%. Across the medical directorate this was achieved in areas of falls awareness, manual handling theory and health and safety. However, attendance to fire safety was 60% and manual handling for patients was 73%. Specialist training for administering blood transfusions was 50%, attendance to basic life support was 63% and attendance for emergency medicine staff and advanced nurse practitioners for advanced life support training was 30%. These figures were year to date.
- Nurses and healthcare assistants told us they knew there were some gaps with their mandatory training, however the priority was ensuring safe staffing levels and they felt training came secondary. This view was echoed by senior staff who told us priority was given to staffing the ward rotas so staff were not always able to attend training.

Assessing and responding to patient risk

- An early warning score system was used throughout the trust to alert staff if a patient's condition was deteriorating.
- We saw that the early warning indicators were regularly checked and assessed. Where the scores indicated that medical reviews were required staff had escalated their concerns. Medical reviews and repeated checks of the early warning scores were documented.
- Patient wristbands had a colour coded system to alert staff if the patient had known allergies or there was a risk of the spread of infection.
- Where patients required NG (naso-gastric) tubes we saw that scans were used to ensure the tubes were correctly inserted into the stomach, reducing the risk of aspiration.
- Patients who were at risk of pulling out their NG tubes were identified and supported with padded mittens to reduce the risk of self-injury.
- All patients who were at risk of pressure damage were supported with appropriate pressure relieving equipment such as airwave mattresses and cushions.
- Nurses did not routinely attend wards rounds as they were too busy, this made communication between nurses and medics fragmented.

Nursing staffing

- Ward managers and senior sisters met three times per day, 8am, 11am and 3pm to discuss bed capacity and nursing staffing levels to ensure beds were occupied and staffing levels and skills were appropriately deployed and shared across all wards.
- Ward sisters across many wards told us staffing levels was a daily concern and a high usage of agency staff was common practice.
- Staffing levels at AMU, Ambulatory Care and wards 9, 10 and 11 was well organised and the skill mix was appropriate to adequately meet patient's needs.
- Ambulatory Care Matron recruited their own nursing staff which had a positive effect as posts were filled with staff possessing the right s skills and knowledge and reduction in the length of time to fill posts.
- Agency staff did not have access to electronic medication administration and were unable to assist with medication rounds, nurses told us this placed increased pressure on permanent staff who were administering medication and also ensuring agency nurses were supported during the shift.
- Wards used the AUKUH acuity and dependency tool, designed to help NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and patient flow. We were told by

ward sisters data was collected and analysed annually to predict staffing level needs, however ward sisters were told they could escalate to matrons at any time if they had concerns about staffing levels or a patient needed one to one support.

Medical staffing

- Medics from all levels from junior doctors to consultants reported being under pressure, particularly on Fridays, especially with the challenge to discharge as many patients as possible to make room for weekend admissions.
- Ward rounds by consultants were daily on weekdays and at weekends only for newly admitted patients.
- Locums were used to backfill medic vacancies, sickness and annual leave.
- There were adequate levels of medics across all medical wards; however there were delays in responding to the needs of medical outlying patients on other wards.

Are medical care services responsive?

Requires improvement

Summary

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

Service planning and delivery to meet the needs of local people

- As a result of high admissions medical patients were admitted to non-medical wards, known as outliers.
- All wards displayed a white board with a red dot to highlight this. Wards 14 and 15 provided predominantly trauma and orthopaedic care had six and five medical outlying patients respectively, staff on ward 15 told us the week before the inspection they had 15 medical outlying patients.
- Medical patients were reviewed regularly by a consultant. However, nurses and medics expressed concern that this was a risk which could mean that patients did not receive the care and treatment because they were not in the "right bed".
- Nurses and medics were concerned staff did not possess the appropriate knowledge and skills to look after patients with medical conditions they were unfamiliar with such as: unstable diabetes, respiratory disease and heart failure.
- Nurses told us, there was a real risk that medical patients were missed from the ward round especially when locum doctors were on duty and unaware of which wards medical patients had been admitted to.
- Requesting a doctor to assess a medical outlying patient often took longer as doctors were conducting ward rounds on medical wards as a priority.

Access and flow

- Senior nurses said there was good strategic management of bed capacity at AMU and effective liaison with the emergency departments to monitor patient flow and bed capacity.
- Ambulatory Care were proactive in assessing, transferring and discharging patients to meet their needs. There were minimal delays in prescribing and dispensing of medication which led to more effective discharge planning and better patient outcomes. Advanced Nurse Prescribers covered Ambulatory care six days per week, resulting in patients receiving assessments and treatment in a timely manner, which had a positive effect on patient flow.
- Wards 8, 11, 14 and 15 had several patients who were medically fit for discharge, however due to social reasons such as awaiting funding and packages of care there was no discharge date. Ward 8 had 20 out of 31 patients waiting to be discharged.
- No patient discharges were carried out until mid-afternoon.
- Junior doctors reported increased pressure particularly on Fridays, exhorting teams to discharge as many patients as possible to make room for weekend admissions. Ward 8 staff confirmed rushed discharges had occurred that week resulting in one patient being readmitted to hospital and one patient's family submitting a formal complaint.

Meeting people's individual needs

- Generally risk assessments were completed on admission and at regular intervals and care plans reflected patient's needs.
- Single-sex bays were in place across all medical wards.

Medical care (including older people's care)

- Specialist nurses for: dietetics, tissue viability and speech and language provided individualized assessments for patients with specific conditions.
- Patients who required assistance to eat and call bells were responded to quickly at AMU, Ambulatory Care, wards 10, 11 and 24 and patients admitted to these wards were very happy with the standard of nursing care and timely medical assessments during day and night. One patient told us they could have had private care but didn't need to as the care on AMU was superb.
- The chaplaincy team offered religious and spiritual support to patients and relatives.
- Interpretation services were available in both language line (a telephone translation service) and face-to-face interpreters, however staff did not always use the service as it took too long to arrange.
- Ward 11 had a strong volunteer programme in place. Patients were supported by volunteers to mobilise and sat and chatted to them.

Learning from complaints and concerns

- Patients across all medical wards were satisfied with the quality of service they received. We were told by several patients nurses were kind and caring but often rushed around the ward.
- Staff followed the trusts complaints policy and provided examples of when they would resolve concerns locally and how to escalate when required.
- PALS (patient advice and liaison service) leaflets were not readily available for patients as they were often displayed by the nursing station and not by the patient's bedside; this was a similar picture across all three hospital sites.

Are medical care services well-led?

Requires improvement

Summary

Staff across all medical wards were dedicated and compassionate, despite the majority of staff feeling despondent. Local leadership was supportive and nurturing. Ward sisters and ward managers demonstrated they cared for their staff as much as their patients. However, staff could not articulate the trust's vision and staff from most wards felt decisions were made without their engagement. However staff from AMU, Ambulatory care, wards 10 and 11 were well led locally, staff felt included about the running of their wards and their opinions were listened to.

Vision and strategy for this service

- We talked to 55 staff from various disciplines and grades across eight wards and no one could articulate the trust or their respective service's vision or future strategy was.
- Individual staff spoke with pride and compassion about what they thought good care looked like and how they demonstrated this on a daily basis.
- Some senior staff were clear on the direction of travel of the trust and told us the key aims was to provide a safe patient journey with a focus on assessment and treatment by the right professionals, in the right place at the right time. However staff from many wards were disheartened and one ward manger told us it's an achievement if they have a full complement of staff each day.

Governance, risk management and quality measurement

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

Leadership of service

- All nursing staff spoke highly of senior sisters and ward managers as local leaders and told us they received good support, particularly at AMU, Ambulatory care, wards 10, 11 and 24. AMU demonstrated strong nursing leadership who were well informed and involved in decision making.
- We observed good working relationships between nursing, therapists, specialist nurses and medical staff across all medical wards, particularly at wards 10, 11 and 24.

- A locum consultant stated Ambulatory Care should be used as a beacon to measure other services against, "It is well run, with sound organisation management and is a credit to the trust".
- Communication between senior managers and local managers was poor. Approximately 12 ward managers had collectively sent a letter of concern to the Chief Nurse raising concerns about lack of support, staff not being listened to, poor staffing levels and heavy handed senior management approach to problem solving.
- The senior management responded by setting up one to one clinics during the inspection with the director of HR for staff members to voice their individual concerns.
- A recent staffing review resulted in staff members moving to different wards. Nurses told us decisions were frequently made by the senior team without ward staff consultation, staff were told after the event and expected to get on with it.
- Annual staff appraisals had not been conducted for all staff this was a similar picture across all three hospital sites.

Culture within the service

- In general we found the culture of care delivered by staff across all medical wards was dedicated and compassionate, despite the majority of staff feeling despondent. We found staff were hard working, caring and committed to the care and treatment they provided.
- Staff spoke with passion about their work and conveyed how dedicated they were in what they did.
- Senior sisters and ward mangers told us they felt decisions relating to the management of their wards and staffing were often taken by senior managers without their involvement and usually with very little notice.
- Staff were aware of some members of the executive team but felt they were not approachable and described the overall trust management style as; forceful and heavy handed.
- Decisions were often made by senior and executive managers with minimal communication with staff; this was the culture across all three hospital sites.

Public and staff engagement

- The NHS Staff survey 2014 showed the overall indicator of staff engagement trustwide was worse than the national average and ranked in the bottom 20% of trusts of a similar kind.
- Staff recommendation of the trust as a place to work or receive treatment was also worse than the national average, worse than 2013 figures and ranked in the bottom 20%.
- Sickness rates from October 2014 showed AMU, ward 10, ward 11 and ward 24 all better than the national average at 4.5%. However, wards 8, 9, 14 and 15 were worse than the national average
- Communication from middle management required improvement as nurses told us they had little opportunity to voice their opinions or concerns and one senior sister told us, " We do what we are told ".
- Staff felt a 'heavy handed approach' was taken to problem solving, for example, ward closures, reopening wards, and management of underachieving wards.

Innovation, improvement and sustainability

- The opportunity for clinical excellence to flourish across medical wards depended on individual team's workload. Many staff we talked to reported their focus was purely on delivering patient care.
- The practice placement team provided excellent links between the trust and the University in supporting more than 600 student nurses across all three hospital sites.

Surgery

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

Information about the service

Good Hope hospital provides inpatient and day surgery for specialisms including orthopaedic, plastic surgery, general, breast and vascular surgery.

We inspected theatres, the vanguard theatre, day case unit, surgical assessment unit and three wards. We spoke with 24 staff and 15 patients. We observed care and reviewed records as part of this inspection.

Summary of findings

Following a never event, meetings were held with staff to discuss lessons learnt and new procedures to prevent re-occurrence. The basement corridor used to transfer patients to theatres was in a state of disrepair. The World Health Organisation (WHO) five steps to safer surgery checklist was not always done in the anaesthetic room, data was input later due to IPAD connection problems which could lead to errors.

There were 62 surgical cancellations in all theatres for trauma and orthopaedics between 1/9/14 and 9/12/14. Data from the trust showed that the Vanguard theatre session times use averaged 73.6%. The main theatres averaged 86.43% against a trust target of greater than 90% usage. Patients perceived staff shortages in some of the surgical wards and several patients reported having to wait a long time for call bells to be responded to.

Staff expressed concerns in relation to challenging senior management about significant issues relating to clinical safety. Staff felt that when attempting to support and speak in favour of their patients they were perceived as obstructive and negative for raising concerns. Staff described an 'Enhanced Recovery Pathway' for orthopaedic patients as an example of implementing national best practice.

Surgery

Are surgery services safe?

Not sufficient evidence to rate

Following a never event of which the hospital had two in surgery in 2013/14. One being a retained swab and the other wrong site surgery trust wide, one of which resulted in a patient required to return to theatres. Meetings were held with staff to discuss lessons learnt and new procedures to prevent re-occurrence were put in place of which we saw an example.

The safety thermometer was in use and visible in the surgical wards. There was no data for theatres. For the Good hope hospital site the incidence of harm free care since mid-January to August 2014 has been better the national average except for one month. For October 2014 the trust achieved 95%, which was a 12 month high. We saw that the data indicated good compliance with VTE assessments, prevention of UTI's in catheterised patients and pressure area care and assessment.

The basement corridor used to transfer patients to theatres was in disrepair and not maintained for several years. It was dirty and in dis-repair with significant holes at several points in the ground. Waste and a pile of bricks were visible in the corridor causing a potential fire risk. Staff informed us that the trust had promised to improve the corridor several years ago but little progress had been made. We escalated this matter and the refuse was removed. We noted that that there was no dedicated patient lift and the one in use was dirty.

We observed one patient being moved with an inappropriate lift, lifting aids such as pat slides were available but not being used.

Fridge temperatures were being checked in theatres. However, we noted on one ward where a recording was out of range, we asked staff what actions they would take. Staff were unable to tell us what or if any action had been taken.

The World Health Organisation (WHO) five steps to safer surgery checklist was not always done in the anaesthetic room, data was input later due to IPAD connection problems which could lead to errors.

Documents supplied by the trust demonstrated that of the surgical medical staff just over 50% of staff had undertaken safeguarding adults level 2 training (34 of 62). Of the 34 who had undertook this training 19 of them had undertook training in 2012, with three having last completed their training in 2011.

Mandatory training was monitored and consolidated at the end of March each year for which the target was 85%. For medical staff we found that measures taken in October 2013 was approx. 77% year to date.

Documents supplied to us demonstrated that since August to October 2014 there was a reduction of falls. We also noted that although a small number of falls had occurred since March 2014 all had resulted in no injury to the patients. The treatment of the deteriorating patient required that a patient be seen by a clinician if their score was 6 or above. We reviewed the results for wards 14-17. We found that all had 100% compliance.

There was no use of an acuity tool to assess staffing requirements. Although the trust did publish it's planned and delivered staffing. Senior sisters have escalated concerns to the chief nurse regarding unsafe staffing levels in relation to the acuity and dependency of patients on the surgical wards. The trust recorded nursing staff shortfall, we reviewed the results for surgical wards 14-17 reported for October 2014 which averaged 46%. There were concerns of the impact this was having on staff morale, which high sickness levels can be associated with. Low fill rates of bank shifts was resulting in higher reliance on agency staff. Staff told us that retention of staff was a challenge and they were currently trying to recruit to vacant posts. We observed that the skill mix on one of the surgical wards was top heavy regarding newly qualified staff.

The medical team were available between 0800 and 1600 and on call out of hours and at weekends. There was an acute shortage of junior doctor anaesthetists with six open vacancies at the time.

Are surgery services responsive?

Not sufficient evidence to rate

There were 62 surgical cancellations in all theatres for trauma and orthopaedics between 1/9/14 and 9/12/14.

Surgery

Data from the trust showed that the Vanguard theatre session times usage averaged 73.6%. The main theatres averaged 86.4% against a trust target of greater than 90% usage.

The Vanguard Unit was set up as a "winter pressure" unit, opened seasonally to take care of low level or local anaesthetic procedures. However, it is often used for overnight inpatient use. It was a purpose built temporary space which was well equipped.

Staff told us that frequently day patients turn up with no beds available for them. Staff had escalated this issue to senior nursing staff. Staff described an 'Enhanced Recovery Pathway' for orthopaedic patients as an example of implementing national best practice. This involved patients pre-operatively attending weekly education sessions by the multi-disciplinary team called 'joint school'. The aim of the pathway is to provide pro-active management to enable earlier discharge. The trust monitors the number of patients spoken to about discharge dates. The target is 95% or more. From April – October 2014 the trust failed to achieve this target averaging 71%.

Patients perceived staff shortages in some of the surgical wards. Several patients reported having to wait a long time for call bells to be responded to resulting in them wetting their beds before they could be assisted to the toilet.

Staff told us special arrangements were put in place for patients living with dementia , for example a familiar face at meal times and open visiting for family members. The trust utilised the "All about me" documents to improve communications with people with learning disabilities.

Are surgery services well-led?

Not sufficient evidence to rate

Staff expressed concerns in relation to challenging senior management about significant issues relating to clinical safety. Staff felt that when attempting to support and speak in favour of their patients they were perceived as obstructive and negative for raising concerns.

The trust supplied us with their risk register, it contains risks which can have a detrimental effect on patient care, staffing or a reputational damage to the trust. We saw that one risk which was trust wide but specific to surgery, involved a recall process. The governance put in place to manage this process appeared robust.

Staff expressed concerns about not being fully informed regarding the new 24 hour working proposals. Staff expressed concerns about not being fully informed regarding reconfiguration of services. They reported they were asked to sign amended contracts before the end of the current consultation.

Friends and family questionnaires are monitored as part of a CQUIN. November 2014 GHH achieved an inpatient response rate of 28%, which meant the trust hit the month target.

Staff described an 'Enhanced Recovery Pathway' for orthopaedic patients as an example of implementing national best practice.

Maternity and gynaecology

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

Information about the service

The Maternity service at Good Hope Hospital manages 3800 births a year, providing care packages for women who require both consultant led (high risk) and midwifery-led care.

During our inspection we spoke to 19 staff, 3 student midwives and 10 patients. We visited the Labour Ward, antenatal clinic, two postnatal wards and the Maternity Assessment Centre (MAC)

Summary of findings

Incident reporting was good and staff told us they had opportunities to learn from issues raised. There were no safer staffing information on display for staff, women and visitors to the maternity unit. The percentage of women having interventional births was higher (worse) than the England average.

Some good initiatives were observed to facilitate efficient and safe admission and discharge, however support for low risk mothers and assistance with breast feeding was minimal. The caesarean section and induction of Labour rates were significantly higher than the national average.

There was some tension between Labour ward and Maternity Assessment Unit staff, regarding admission criteria for women.

The Maternity department at Good Hope Hospital lacked visible leadership and the staff were unclear about the maternity strategy and felt powerless to affect service development and delivery. Staff worked well in their teams, but there was little inter-department co-operation, and some staff told us they worked in a 'blame culture' which lead them to practicing defensively.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Summary

Transparency of safety standards at Good Hope Hospital could be improved, as there were no 'safer staffing' materials displayed in ward areas to inform staff and the public about staffing levels.

The Midwife to patient ratio was worse than the recommended average, and there were concerns raised about staffing the second obstetric theatre at night and how this affects safe care.

The percentage of women having a Caesarean section or Induction of Labour was significantly higher (worse) than the average rate for England, and there was a lack of emphasis in providing 'low risk' care for women.

Incidents

- No Never events have been reported for this hospital since 2012. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Senior staff did refer to five never events, however they were not aware that these all happened at Birmingham Heartlands Hospital
- Most staff said they were aware of how to report an incident and that they would receive feedback either individually, or wider learning would be disseminated in the staff communications 'Matty Chat' and the Governance Team Newsletter
- Staff highlighted that the electronic incident reporting system did not easily allow them to report staffing incidents, and it was found that the 'staffing' category had been removed. Staff believed that this had happened as too many staffing incidents were being reported. It was still possible to report incidents attributed to poor staffing, however staff had developed a 'workaround' in order to do this

Safety thermometer

- There were no patient safety information displayed for staff or visitors displaying key safety or infection control indicators. Staff were informed about performance against key performance indicators by a trust wide communication 'Midwifery Metrics News' which detailed site and individual ward performance but was not linked to trust wide or national targets
- In September 2014 Good Hope Hospital reported a total caesarean rate of 38%, 13% above the rate for England in 2012-2013 (BirthchoiceUK, 2015) and an Induction of Labour rate of 30.4%, 7% above the average rate for England in 2012-2013 (BirthchoiceUK). Neither of these statistics were reported against trust or hospital targets or appeared on the communication circulated to staff or on the Midwifery dashboard.
- The trust was taking part in a national pilot of a Maternity Safety Thermometer and had submitted data in six of the possible 11 months the pilot was running.

Cleanliness, infection control and hygiene

- Infection control standards and results were published monthly as one figure across the three hospitals. Compliance for hand hygiene, bad space and cleaning, uniforms, and alcohol get had merged with privacy and dignity indicators and aggregated to a final percentage. This is circulated to staff via the Midwifery Metrix news although displaying of individual ward compliance was not observed.
- Equipment was observed waiting to be used without green 'I am clean' stickers on. Staff told us these were often not available.

Environment and equipment

- There was no working blood fridge on Delivery Suite as it had broken approximately two months before our visit, although it was still in situ. Staff reported that if there was a perceived risk of a woman bleeding, a porter was required to sit outside delivery suite to run for blood from the central blood bank, which was on different floor in the hospital. This was not documented on the maternity risk register. Following the inspection the trust confirmed a new fridge was in place.
- The delivery room equipped for 'low risk' deliveries was being used as a store room for boxes, blankets broken equipment with cages filled with stock blocking its entrance.
- Staff reported lack of equipment and stock, especially on the postnatal ward, namely blood pressure machines and baby tags.
- There were no records available demonstrating staff competency specifically to use the hoist over the birth pool, or an evacuation procedure documented.

Maternity and gynaecology

Medicines

- Although a box containing emergency medication for pre-eclampsia was present, staff were unsure where it was kept and it was eventually found in a cupboard in the high dependency room. Given that this was to be used in the event of an emergency staff should have been aware of its storage.

Records

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff receive safeguarding training every 3 years which includes mental capacity act training.

Safeguarding

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

Mandatory training

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

Assessing and responding to patient risk

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

Midwifery staffing

- The Obstetrics Directorate used Birthrate Plus as an acuity tool and a review (across the three hospitals) was conducted in 2011 and 2012. A 1:34 Midwife to Birth ratio was reported, in contrast to the 1:28 which would be recommended for a midwifery unit caring for some women who were high risk.
- Good Hope Hospital was five whole time equivalent midwives under establishment, and there were plans to recruit to these posts in 2014/2015. There was no visible safe staffing matrix in the ward area.
- Many staff told us about their concerns about inadequate staffing and the need to move staff from the wards to delivery suite mid-shift on a daily basis. They told us they were often not able to take breaks and there was a lack of forward planning to anticipate staff shortages on a shift by shift basis. Midwives did, however feel that they could always provide 1-1 care in Labour, however this was due to their flexibility and sound teamwork, rather than having adequate staffing.
- There was a particular concern raised about the staffing of the second obstetric theatre at night, as women requiring an emergency caesarean section could not go to theatre in a timely manner as there was no second scrub nurse on the premises. This was sometimes resolved by a Midwife leaving the patient she was caring for and scrubbing in theatre. This was documented on the Obstetric Risk Register.

Medical staffing

- The Hospital has the provision for 60 hours per week consultant presence for Labour Ward. There is one registrar and one senior house officer present at night, with a consultant on call within 30minutes of the obstetric unit.
- There was 24 hours of anaesthetist cover available, with consultants present during the day to service the elective list and emergencies, and a trainee present at night. The trainee rota was challenging to cover as the number of trainee anaesthetists is declining nationally, so the rota was frequently covered by locums.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good

Summary

Good Hope Hospital had implemented some excellent initiatives to ensure that admission and discharge were facilitated in a timely and safe manner.

There are good facilities for women with a disability to be cared for safely on both the Labour and postnatal wards.

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

Service planning and delivery to meet the needs of local people

- We saw minutes of the Maternity Services Liaison Committee which met Bi-monthly. Clinicians and managers from all three sites attended, along with representatives from SANDS (Stillbirth and Neonatal Death Society), and other local community groups representing women and children.
- We were advised that the maternity service estate redesign 'Pelican' Project would be meeting with local groups to involve them in the planning and delivery of maternity services, and that MSLC (Maternity Service Liaison Committee) and SANDS representatives were already engaged.
- Staff could not tell us how service users were engaged to influence the design and delivery of services, and advised us there was not a service user representative on the Labour Ward Forum.
- The postnatal ward tried as much as possible to accommodate partners to stay overnight, using side wards whenever possible or reducing bay occupancy to increase privacy.

Access and flow

- A 'RAG rating' (Red Amber Green traffic light) system has been implemented in the Maternity Assessment Centre (MAC), in order to triage women over the telephone to assess the appropriate place of care. The MAC is open from 8am to 8pm, and outside of these hours, women are triaged on the Labour ward. Staff on both the Labour ward and the MAU referred to tension between the two departments regarding where a woman should be seen, and the MAU Midwives felt the 'rag rating' system gave them 'back-up to stand our ground' when they felt the most appropriate place for a woman to be admitted to was the Labour ward.
- The postnatal ward also 'RAG' rated how soon women could go home at the beginning of every shift, in an attempt to reduce any delay in discharges.
- Midwives on the postnatal ward had undertaken additional training to enable them to undertake the examination of the newborn. They had completed 70% of all examinations in 2014, which meant that women were not waiting on the ward longer than necessary for a paediatrician, hence expedited their discharge. This initiative was Midwife –led and made them feel proud to have influenced improved service delivery.

Meeting people's individual needs

- A hoist was available to assist woman with a disability to enter and leave the birth pool on Labour ward, and two rooms on the postnatal ward were suitable for women who were wheelchair users.
- Staff in the antenatal clinic told us that the use of interpreters has been reduced, partly due to reducing costs, but also as a female translator could not always be guaranteed which was not acceptable to some women Language line was available, although it's use was restricted to certain locations so privacy cannot always be guaranteed.
- 'You said, we did' posters were displayed throughout the unit, although they were displaying information collected from surveys conducted in 2012.
- Although Good Hope Hospital has Level 3 UNICEF Baby Friendly accreditation patients interviewed on the postnatal ward complained the lack of breast feeding support available, and staff told us they felt they did not have sufficient time to sit with women to help facilitate breast feeding. The Infant feeding co-ordinator role had recently been realigned to cover both Good Hope Hospital and Birmingham Heartlands Hospital, and both women and staff at Good Hope felt that women received a downgraded service because of this.

Learning from complaints and concerns

- Staff described the complaints procedure and understood the escalation procedure if a complaint could not be resolved immediately. They were encouraged to be open and honest with the

complainant and apologise if they felt they had received poor care. PALS leaflets were available; however staff said that they were not aware of any lessons learned or changes of practice that arose from upheld complaints.

Are maternity and gynaecology services well-led?

Requires improvement

Summary

The Trust has a clearly documented, easily available strategy for maternity services; however knowledge of this was not demonstrated by staff we talked to, and some of the practices we saw did not support this vision, for example lack of support for low risk birth.

We found a lack of visible leadership with no clear plans to address this, and a workforce that felt powerless to affect quality and service delivery.

Teams worked well within their clinical areas, but did not support other departments, and staff talked of a working in a 'blame culture'.

Vision and strategy for this service

- The Trust had set out its' vision in a Maternity Strategy document, which was available on its website and in several different languages, however all staff questioned who were band 7 and below did not know of its existence or content.
- One of the key priorities in the Maternity strategy was to facilitate the availability of a midwife –led birth unit on the Good Hope Hospital site. This vision was in direct contrast to the ethos we saw on the Labour ward, where the 'low-risk' birth room was not fit for purpose and staff told us the birth pool was rarely used. The lack of focus on providing low risk midwifery care was demonstrated by the higher than national average caesarean section and induction of labour rates.

Governance, risk management and quality measurement

- We observed an attitude to risk management which was sometimes reactive rather than evidence based. When asked about the lack of support for midwife –led birth on the Labour ward, the senior management team advised that this was because of some incidents of high risk women being treated as low risk, resulting in poor outcomes. The decision had been made to medicalise low risk women as this was considered safer.
- There was no documented evidence of a risk assessment concerning the lack of blood fridge on labour ward, and this was not found on the local risk register

Leadership of service

- Staff spoke of a lack of senior leader visibility, with many not familiar with the senior leadership structure and unable to tell us the names of senior leaders within the Maternity directorate or to say when they last saw them.
- The Head of Midwifery stated that it was impossible for her to be visible across the three sites, however had invited all Band 7's to attend a meeting to support their development and increase her visibility.
- There was instability at operational Matron level, with sickness leading to staff in Matron's posts who had received little training or support. On Labour ward both existing and aspirant Band 7's felt unsupported and burdened by feeling responsible for the actions of every midwife on duty, even when problems hadn't been escalated.

Culture within the service

- Midwives told us there was a lack of consistency surrounding decision making of obstetric consultants, and a culture where one consultant would not challenge or change another consultant's decision.
- Several Midwives talked about a 'blame culture' which lead them to practice defensively. They felt if an incident occurred then there was no support during the investigation and they were 'guilty until proved innocent'
- Staff told us that they were proud to be part of the team they worked in, and this was what they enjoyed about the job. There did appear to be tension between the ward areas, Labour ward and the MAC which prevented them working collaboratively to deliver good quality care.
- The most recent Local Supervisory Report stated that the Supervisor of Midwife to Midwife ratio for the overall trust was 1:18 (worse), against a recommended 1:15, however they were reassured that the trust was actively

recruiting Midwives to become Supervisors of Midwives to address the deficit. There was a Supervisor of Midwives rota that provided 24 hour a day, 7 day a week on-call cover across the three sites.

Public and staff engagement

- Labour ward staff voiced dissatisfaction in the way they were engaged and had the opportunity to influence the planning and delivery of their service. They had contributed to a Maternity Quality Review in August 2014, but the results had not been fed back or discussed.
- Staff told us that the criteria for inviting women into Labour ward had changed in response to an incident where a woman having ante-partum haemorrhage had been advised she was experiencing a normal 'show', leading to an increase in admissions and interventions. They had raised this as a concern but did not feel appropriate action was being taken to investigate this.
- Senior managers described the 'Pelican Project' which addresses redesigning the maternity estate and pathways, although they commented that this needs to be re-energised and staff and stakeholders need to be more engaged.

Innovation, improvement and sustainability

- The trust strategy sets out an improvement in midwifery (especially community) resources, a focus on normal birth, and improved choice and outcomes for women and their families as their key priorities for 2014/2015. No staff we talked to were aware of these proposals, however they were concerned about the sustainability of the Good Hope site and being 'Taken over' by Birmingham Heartlands Hospital.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department is mainly housed within the treatment centre at Good Hope Hospital. However the trauma clinic is co-located with the outpatient physiotherapy department. Paediatric outpatients is to be found near the Emergency department whilst ophthalmology and oncology is located in Sheldon house. We visited the main outpatients departments and saw approximately 15 clinics running. We also visited the paediatric outpatients, and the trauma outpatients clinic. We reviewed the practices of the main outpatients department, pathology, radiology and went to the central booking service for outpatients at Linden Place. Services within the radiology department included plain x-rays, intervention, ultrasound, nuclear medicine, and CT and MR scanning.

We spoke with 13 members of outpatients staff, the bookings manager, five members of diagnostic services staff and 13 patients.

Summary of findings

The outpatients department at Good Hope Hospital required improvements to be made in order that safety and the responsiveness to the needs of patients improved. Incident reporting was poor as was the feedback process from any investigation of incidents to staff. This meant that the department could not learn and improve services. Infection control processes required improvement as staff did not adhere to trust policies in this area. Performance data which would have assisted the department to develop and improve was not available to senior staff and therefore the team were unaware of issues requiring action. The leadership of the department was felt by staff to require improvement as action had not been taken to address identified issues.

The diagnostic departments functioned well and were responsive to patient's needs. Despite national shortage in radiology staff the department was led by leaders who supported staff and championed improvements to services. Processes within these departments were in place to ensure that they were safe and responded to the changing needs of the patients and services within the hospital.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

Summary

Information about safety is not always comprehensive or timely within the outpatients service at Good Hope Hospital. Safety concerns are not consistently identified or addressed quickly enough. There was limited use of systems to record and report safety concerns, incidents and near misses. Staff reported that they rarely reported incidents however the department had reported a significant number of incidents in the previous six months. Feedback from these incidents was not given to staff in order that services could improve. Infection control processes required improvement to ensure that the department was clean and that staff adhered to current trust policies.

Incidents

- Staff in the outpatients department felt that the department was safe as they rarely reported any incidents on the computer reporting system. We saw that the department had reported 79 incidents within the previous six months.
- Although most staff were aware of how to report incidents or to raise concerns they stated that they would not report late running of clinics or cancelled clinics as an incident this meant that opportunities for identifying trends and learning and hence improvement were lost.
- We could not follow an incident to ensure that investigation and learning had taken place as staff could not remember when the last incident occurred. Neither could staff discuss any action taken as a result of an incident within the hospital or trust
- The radiology department complied with the Ionising Radiation (Medical Exposure) Regulations (IRMER) through monitoring and reporting of incidents..

Cleanliness, infection control and hygiene

- The environment was visibly clean but there were no records in place to confirm that clinic rooms had been cleaned. Staff told us that they cleaned the clinic rooms at the start of a clinic but there was no evidence to support this.
- Staff were aware of infection control processes such as use of personal protective equipment and hand hygiene. A noticeboard was dedicated to infection control issues however this contained no data on the performance in audits such as hand hygiene audits within the department.
- We saw half of the care staff available in the outpatients department were wearing cardigans. These were full length sleeved cardigans which had not been rolled up to ensure that the trusts bare below the elbow policy was adhered to. We also saw that staff infrequently washed their hands.
- Diagnostic areas were visibly clean and within the pathology department staff took active measures to ensure that infection control issues were appropriately dealt with. The pathology department undertook various audits to ensure cleanliness and infection control systems were in place.

Environment and equipment

- Equipment was maintained and PAT tested in line with trust policy. Labels were seen on equipment which identified when this had been last checked. All equipment seen had been checked within the previous year.
- There were two resuscitation trolleys in the outpatients department at either ends of the circular corridor. We checked both of these trolleys to ensure that stock was in date and items were available. The resuscitation trolley in the women's clinic was checked on a daily basis and all equipment was seen to be within the expiry date. However, the resuscitation trolley found in bay C had been checked only 11 of 20 working days for November.

Medicines

- Medicines were kept in locked cabinets and keys were maintained by outpatient personnel. Within the radiology department controlled drug cupboards were securely maintained and reconciliation was undertaken on a regular basis.

Records

- Medical records were available for clinics. The central booking system sent copies of clinic lists to the medical records department to ensure that patients records

were sourced prior to the clinic occurring. However there was no check on the numbers of records not available for clinics undertaken to ensure efficiency of this system.
- Medical staff recorded in patients records and care staff recorded basic monitoring of patients weights and diagnostic tests as appropriate.
- Risk assessments were not generally undertaken within the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of caring for people who may have limited capacity but were unaware of the deprivation of liberty safeguards. They saw these as irrelevant for their department. Most patients attended the department of their own free will.
- Staff undertaking procedures were aware of consent implications and completed the appropriate documentation as necessary.
- Implied consent was taken for examinations and basic testing of patients metrics. Staff explained procedures and patients willingly submitted to having these undertaken.

Safeguarding

- Safeguarding training had been undertaken and information was available on the noticeboard. However staff felt that this didn't really apply to their department. Staff were unable to remember the last time they had referred anyone to the safeguarding team internally.

Mandatory training

- Staff undertook mandatory training (not corroborated) this was done through e-learning and through face to face training.

Nursing staffing

- The department was fully staffed as per their budget. There were 10 registered nurses and 15 healthcare assistants.
- Trained nurses were used to undertake complex clinics and undertook nurse led clinics.
- The majority of clinics were undertaken by healthcare assistants. During our inspection we saw only two registered nurses in the main outpatient department, both these nurses were busy with nurse led clinics and there was little supervision of the healthcare assistants. Healthcare assistants felt that they could approach a nurse but that they were often busy.

Medical staffing

- Medical staffing was provided by the specialty holding the outpatient clinic. A variety of medical and allied healthcare professionals were available within the outpatient department.
- In general clinics were held by senior medical professionals.
- Following retirement there were two vacant consultant posts within the radiology department which meant the department lacked expertise in paediatric radiology.

Major incident awareness and training

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

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

Summary

The outpatient department was not responsive to the needs of patients using this service. Services are delivered in a way that is inconvenient and disruptive to people's lives. Clinics are not available out of working hours apart from a few new clinics initiated recently. This is despite most staff reporting that the biggest single complaint from patients following car parking charges was the delay in clinics and the need to return to work. Complaints are not used as an opportunity to learn. Booking systems were ineffective with patients being sent to the next clinic rather than clinics held in their local hospital. There are disparate systems for different types of referral which mean that some patients referred by written letter waited longer for appointments than those who are referred either electronically or through Choose And Book systems. It was unclear as to how many clinics were cancelled at either short notice or within the allotted six weeks as no audits were undertaken. Similarly audits were not undertaken of delays and overrunning clinics. This meant that improvements in responsiveness cannot be planned or implemented.

Service planning and delivery to meet the needs of local people

- We saw that three clinics had been planned for Saturday and two on Sunday mornings. Staff were unclear as to

why these had been initiated and told us that this was in response to waiting times rather than to be more flexible in service delivery to meet the needs of patients. Services were staffed by the staff from outpatients who worked overtime to cover these, however on the previous weekend no doctors had turned up for these clinics.

- There were no booked evening clinics despite staff telling us that the main two complaints were parking and delays in clinics causing stress for patients as they needed to get back to work.

Access and flow

- The hospital was not meeting 18 week referral to treatment times and were beginning to undertake some initiative clinics to address this issue.
- Bookings are collated centrally for all outpatient departments. The trust ran two systems for waiting lists one of which ran the risk of breaching the 18 week RTT. There was no evidence of monitoring the length of time it takes to book patients from GP referral letter.
- However, no one monitors the length of time it takes to book patients from referral from their GP.
- Four years ago the booking service initiated a telephone contact system in order to try to reduce non-attendance (DNAs) at outpatient clinics within the trust. This involves 12 staff each working 15 hours weekly. The booking office was unable to provide any evidence that this initiative had had any effect on reducing numbers of non-attenders. We were informed that non-attenders were not routinely given another appointment.
- Within the outpatients department there was a main desk where patients report to on arrival. We saw that there were often long queues to register at this desk. There was nowhere for patients to sit in order to wait within this queue.
- Once passed the main reception patients booked in with the relevant clinic window and took a seat in the area near to this window. Staff called patients through to clinic when the medical staff are ready to review them.
- Staff could tell us which clinics always ran late and which were often delayed. However there was no signage for patients to inform them of delays in clinics. This was done in an adhoc manner by staff announcing in waiting rooms delays to clinics. Patients who felt that they had been waiting too long often enquired at the booking window as to how long they would be.
- In radiology investigations on inpatients were carried out without significant delay and reported on the same day. Investigations on outpatients were generally undertaken within two weeks and reported over the following two weeks. The reporting service was under considerable pressure and, in response; some reporting was outsourced to a private company when delays in reporting were increasing within the department, although the outsourcing service was also struggling to meet demand.
- A duty consultant was available within the radiology department to deal with any clinical matters brought to him by clinical staff within the hospital visiting the department or by telephone, and members of the radiology staff within the department.

Meeting people's individual needs

- We followed the existing signage to the outpatients department to find that it was not in the signed area. However, outpatients was to be found mainly in the Treatment Centre and this was well sign posted.
- Staff were aware of dealing with patients who may be vulnerable. They did this by seating them close to the clinic doors so that they could see them. They also tried to move them forward in the clinic list so that they were in the department for the least possible time.
- Patients with learning disabilities were similarly treated and moved up the list. However there was no flagging system for any patient with special needs.
- There was an awareness of dementia but no special training had been given. Care is dependent on the person organising the clinic.
- Wheel chairs were available within the department but these were not easily seen from the main entrance as they were stored under the stairs.
- There were a number of specialist staff available in clinic to provide information to patients; diabetes nurses were available as were urology and gynaecology nurse specialists.
- There was a note on the whiteboard in the staff areas which stated that relatives should not be used to translate and staff were aware that there was a translation service available within the department.
- There were a lack of leaflets available within the clinic environment for specific conditions. However within the clinic was sited the Patient Advice Liaison service. This

desk was unmanned during our inspection and had boxes on the chairs meant for staff. There were no leaflets on the service available however boxes of leaflets were available underneath the exposed counter.

Learning from complaints and concerns

- Staff could not remember the last time someone made a formal complaint; hence staff could not express learning from complaints. However when asked about what worried them most in the department staff stated that giving a poor patient service worried them most and that patients complaining about delays in clinics was their biggest concern. However this occurred on a regular basis. These complaints were not recorded to see how often they occurred or so that lessons could be learnt from them.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Summary

The arrangements for governance and performance management did not always operate effectively. Opportunities for improvement in the service, identified through audit and monitoring of the service, needed to be initiated and embedded. Whilst staff felt passionate about giving a good service they did not feel actively engaged or empowered. Teams were working in silos and did not always work cohesively. There was a limited approach to obtaining the views of people who use services and other stakeholders. Feedback received was not always reported or acted upon in a timely way. There was a lack of systems and processes for collating, disseminating and learning from these processes was poor.

Vision and strategy for this service

- There was no recognition of a strategy, vision or values within the department. Staff were unable to articulate a vision or plan for the department. One muted that there may be a plan to move specialities from Good Hope to other hospitals, another thought that the department may be privatised but this had not been confirmed.
- Staff were clear about their role in contributing to the overall goal of the department and were determined to provide a good service to patients.

Governance, risk management and quality measurement

- There was a lack of governance systems to ensure the department improves.
- We saw no evidence of any audits or improvements to the service. Staff were unable to verbalise that there were any audits.
- Staff spoke about the cancellation and delays within clinics but we were unable to corroborate this information as data was not collated at departmental or booking centre level.

Leadership of service

- The outpatient manager worked predominantly in the trauma clinic which was at the other end of the hospital. The treatment centre was managed by a band six nurse who was not available during our inspection.
- The treatment centre lacked overt leadership. There was no supervision of healthcare assistants in the department on the day of our inspection. The two registered nurses at work within the department were not available to supervise healthcare assistants or to provide support to these members of the team. Healthcare assistants were allocated “simple” clinics and on the first floor they did not have access to registered nursing staff to support them.
- Staff and leaders told us that team meetings rarely occurred the last one being about 18 months ago. The management preference of the outpatient manager was to have individual discussions with the appropriate personnel rather than have large team meetings.
- Appraisals were undertaken annually between April and October but there was no other form of formal supervision. Staff were confident that if performance of an individual was not appropriate that this would be managed outside of the appraisal system currently in place. However we saw no indication of this despite one member of staff being singled out as difficult to work with.
- Staff in radiology generally felt well supported by colleagues and that multidisciplinary working within the department was good.

Culture within the service

- Staff within the department felt that managers did not support the department. Staffing issues were not dealt with appropriately by senior staff impacting on the culture of the department.

Outpatients and diagnostic imaging

- Staff felt that the managers had an open door policy and that they were approachable but action taken to address issues was limited.
- Staff reported that the department was a close knit community of people who had worked there for some time and took a genuine interest in each other. However there were obvious tensions within the department which manifested themselves through rolled eyes and other facial expressions of staff.
- The diagnostic departments were well led. The staff may have had low morale due to decisions made by senior managers they felt that local managers supported them in their day to day working lives.

Public and staff engagement

- There was little evidence of staff or public engagement in the department. Information for staff was cascaded through use of the intranet and by placing notices on the noticeboard. However on review of the noticeboard it was hard to see the most up to date information as previous notices had not been removed. We saw resilience newsletters from June 2014 on the board.
- Staff reported that management did not listen to their issues and did not address them. Staff told us that the management were not visible and they did not know who was above their immediate line manager.

Outstanding practice and areas for improvement

Outstanding practice

Medicine

- The Practice Placement team provided excellent links between the trust and the University in supporting more than 600 student nurses across all three hospital sites.
- AMU, Ambulatory Care, wards 10, 11 and 24 provided excellent local leadership, services were well organised, responsive to patients individual needs and efficient which resulted in excellent patient outcomes.

Areas for improvement

Action the hospital MUST take to improve

ED

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

Medicine

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

Maternity

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

OPD

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

Action the hospital SHOULD take to improve

ED

- The trust address the ambivalence held by staff about the impact reporting incidents has on learning and improving the quality and safety of the service.
- The trust should take steps to address staff understanding of the value of learning from patient's complaints and better promoting the public engagement methods already in place.
- The trust should ensure that patient's whose first language is not English are supported to understand the emergency department services and systems.
- The trust should ensure that patient's with complex needs such as mental ill health, dementia or learning disability are appropriately supported through their experience of emergency department services.
- The trust should ensure that staff working in the ED department are made aware of a vision and strategy for the service and their contribution to achieving it.

Medicine

- The trust should improve on mandatory training attendance and also specialist training such as: administering blood transfusions and advanced life support training.
- The trust should continue with its Registered Nursing recruitment process and reduce the use of agency staff as a priority.
- The trust should ensure staff are given training how to report poor staffing levels via the electronic system.

Outstanding practice and areas for improvement

Surgery

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

Maternity

- The trust should ensure staff have an opportunity to contribute to planning of future service delivery.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(2(b)(f) Lack of robust incident reporting and feedback which could result in learning opportunities lost. Management of patient handover, overcrowding and timely assessments undertaken in ED Patients waiting over 30 minutes in recovery Service delivery and improvement in OPD with the use of management reporting data.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(g)(h) Within ED cleaning practices needed to improve. Within the trust staff were not adhering to the trust policy.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15 (1) (f)

This section is primarily information for the provider

Requirement notices

Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Lack of equipment and faulty equipment not being replaced in a timely fashion.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (4)(b) (5) Safeguarding processes were not in place for people wearing mittens within the trust.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(1)(2)(a) Nursing staffing was insufficient in places having a direct impact on patients. For instance not being able to staff the second obstetrics theatre in maternity. The appraisal rate for staff within the trust was at 38%. This rate had the potential to impact on the level of care patients received. Manager also lost the opportunity to support staff and identify areas where additional support was required. In addition the visibility of the head of midwifery continues to be an issue as identified during our previous inspection November 2013.