# Manor Hospital

Moat Road
Walsall
West Midlands
WS2 9PS
Tel: 01922721172
www.walsallhospitals.nhs.uk

Date of inspection visit: 8 and 9 Sept 2020
Date of publication: 17/11/2020

## Ratings

| Overall rating for this hospital | Requires improvement |
|---|---|
| Are services safe? | **Requires improvement** |
| Are services effective? | **Requires improvement** |
| Are services caring? | **Good** |
| Are services responsive? | **Requires improvement** |
| Are services well-led? | **Requires improvement** |

# Summary of findings

## Overall summary of services at Manor Hospital

**Requires improvement**

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust serves a population of around 270,000. Acute hospital services are provided from one site, Walsall Manor Hospital. Walsall Manor Hospital has 429 acute beds. There is a separate midwifery-led birthing unit (this is currently not operating but due to open in October 2020), and the trust's palliative care centre in Goscote is their base for a wide range of palliative care and end of life services.

Facts and data about the trust:

- Total number of inpatient beds – 429 as at September 2020
- Total number of outpatient appointments between April 2019 and March 2020 – 518,051
- 3,594 whole time equivalent staff as at April 2020
- A and E attendances from April 2019 to March 2020: 83.537 attendances
- Number of deliveries from January 2019 to December 2019: 3,438

We carried out a short notice announced focused inspection of the emergency department and maternity service at Manor Hospital on the 8 and 9 September 2020, in response to concerns around safety and governance. At the time of our inspection the department was operating under COVID-19 infection, prevention and control measures.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry. For the emergency department we looked at the safe and well domains and aspects of the responsive domain. For maternity services we looked at the safe and well led domains and aspects of the effective domain.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of a regulation and issued a requirement notice or acted under our enforcement powers. in these cases, the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated during this inspection. However, the ratings for well led (in urgent and emergency care and maternity services), and therefore the overall ratings went down. We rated these areas as requires improvement. Please refer to the 'areas for improvement' section for more details.

**Our key findings were:**

**Urgent and Emergency Care**

- The service provided mandatory training in key skills but completion levels for staff in the department were low.
- The service controlled infection risk well.
- The documentation of sepsis screening/management was not robust and required further scrutiny to ensure the safety of patients.
- The service did not have enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not keep detailed records of patients' care and treatment.

# Summary of findings

- The service managed patient safety incidents well.
- People could access the service when they needed it and received the right care promptly.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.
- Leaders and teams did not always manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.
- Systems for sharing of information with external bodies were not always effective.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

**Maternity Services**

- The service provided mandatory training in key skills to all staff and made sure everyone completed it
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service mostly had suitable premises and equipment.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service mostly collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. However , systems for monitoring the provision of staffing were not robust.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

# Summary of findings

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

We found areas for improvement including breaches of legal requirements that the trust must put right. These can be found in the 'Areas for improvement' section of this report.

**Heidi Smoult (Deputy Chief Inspector Midlands)**

# Urgent and emergency services

**Requires improvement**

## Summary of this service

Walsall Healthcare NHS Trust has a purpose built emergency department (ED) that is part of the Manor Hospital. As a result of the COVID-19 pandemic the department had been split into two separate assessment streams for patients, those with potential or confirmed COVID-19 and those without any COVID-19 concerns.

For the COVID-19 stream there was an ambulance triage room, a four bedded resus area which included a dedicated paediatric bed, eight cubicles for the treatment of patients.

For the non-COVID-19 stream there were two triage rooms, a resuscitation area with two beds, one which could be used for paediatrics, five high dependency beds and seven cubicles. There was also an ambulance triage area for up to six trolleys. In the paediatric department there was a triage room, one treatment room for suspected COVID-19/non-infectious children and a separate treatment and triage room for potential COVID-19/infectious patients. There is an urgent care centre that is located on the same site and that shares an entrance and reception area with the ED, this is managed by a different provider and was not inspected.

From July 2019 to July 2020, there were 82,372 attendances at the trust's urgent and emergency care services. This included adults (65,862) and children (16,510 patients) attendances for both majors and minors treatment.

We visited the ED as part of our unannounced focussed inspection on 8 and 9 September 2020. We spoke with 15 members of staff across a range of roles and looked at 22 sets of patient records.

During the last inspection in March 2019 we rated urgent and emergency services as good overall with effective, caring, responsive and well led rated good and safe rated requires improvement. We told the trust they must improve mandatory and safeguarding training compliance for all urgent and emergency care staff. (Regulation 18). We also told the trust that they should improve waiting target compliance levels for triage and treatment in the urgent and emergency for all patients and they should consider replacing old or missing equipment in the urgent and emergency department.

## Is the service safe?

**Requires improvement**

Our rating of safe remained the same, we rated it as requires improvement because:

The service provided mandatory training in key skills but completion levels for staff in the department were low.

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, documentation of sepsis screening/management was not robust and required further scrutiny to ensure the safety of patients.

The service did not have enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.

Staff did not keep detailed records of patients' care and treatment.

# Urgent and emergency services

## Is the service responsive?

**Good**

Our rating of response remained the same. We rated it as good because:

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line or better than national standards.

## Is the service well-led?

**Requires improvement**

Our rating of well-led went down one, we rated it as requires improvement because:

Leaders and teams did not always manage performance effectively. They did not always identify and escalated relevant risks and issues and identify actions to reduce their impact. However, they had plans to cope with unexpected events.

Systems for sharing of information with external bodies were not always effective. Senior leaders in the department demonstrated they had a limited understanding of performance across the department

# Detailed findings from this inspection

## Is the service safe?

**Mandatory training**

**The service provided mandatory training in key skills but completion levels for staff in the department were low.**

During our previous inspection in March 2019 we told the provider they must improve their mandatory training compliance rates.

Staff received mandatory training in; conflict resolution; fire safety; annual fire local arrangements; equality, diversity and human rights; information governance and data security; health, safety and welfare; load handling; patient handling; IPC; safeguarding children and adults and prevent. The mandatory training topics were based on the core skills training framework that the trust had adopted in January 2020.

During this inspection we found that not all staff working in the department kept up to date with mandatory training. The trust set a mandatory training target of 95%.

Across all of the courses nursing staff had an average completion rate of 68% and nursing support staff had an average completion rate of 65%. The mandatory training target was only met by nursing support staff on the prevent level 3 course.

Career grade doctors had an average completion rate of 61%, consultants had an average completion rate of 68% and training grade doctors had an average completion rate of 42% for August 2020 across all of the mandatory training topics.

Managers monitored mandatory training and alerted staff when they needed to update their training. During the inspection staff told us that completion rates of mandatory training had dropped due to the pandemic. We were also told that all of the mandatory training modules had been converted to online courses to aid staff in accessing these courses.

The trust had recently appointed two new practice development nurses for the department. Part of their role was to ensure that staff in the department had completed their mandatory training.

All medical staff working in the department had up to date Advanced Life Support (ALS) and European Paediatric Advanced Life Support (EPALS) training apart from two who were booked onto these courses.

All nurses had ALS training apart from one who was booked to attend training in November 2020. All eligible nurses had completed their European Paediatric Advanced Life Support training.

Between March to August 2020 there were 12% of day shifts without a member of staff with EPALS training and 8% of night shifts. The trust reviewed all incidents submitted on shifts where there was no EPALS cover. There was a total of one sub-optimal staffing incident submitted but this has been reviewed this did not caused any patient harm. Following the inspection we raised this as an area of concern to the trust. They told us that all junior doctors and specialist registrars had completed EPALS and APLS so suitably trained staff were available. They also reviewed shifts from the 28 March to 26 August 2020 and found that there was always a doctor or advanced care practitioner on shift where the paediatric nurse did not have the qualifications.

The trust did not have formal sepsis training for substantive medical or nursing staff. All rotational junior doctors who worked in the emergency department had sepsis training as part of their induction. Half of the paediatric nursing team received sepsis training as part of their annual clinical update and the remaining half were booked onto training within October and November 2020. Following the inspection, we raised sepsis management with the trust as an area of concern and the trust told us they were formulating a plan for sepsis training in the department, however we were not provided with a completion date for this.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although training rates were not always met. The trust had plans in place to improve completion of safeguarding level 3 training.**

Staff received training specific for their role on how to recognise and report abuse. The trust set a target of 95% for completion of safeguarding training. During the last inspection in March 2019 we told the provider it must improve its safeguarding training completion rates.

The current completion rates for nursing staff were:

- safeguarding children level 2- 94%
- safeguarding children level 3- 59%
- safeguarding adults level 3- 50%
- prevent level 3- 75% .

The completion rates for medical staff were:

- safeguarding children level 3- 51%
- safeguarding adults level 3- 37%
- prevent level 3- 55%.

The completion rates for nursing support staff were:

- safeguarding children level 2- 77%,
- safeguarding adults level 1- 100%,
- safeguarding adults level 2- 83%,
- prevent level 1 and 2- 83%
- prevent level 3- 100%.

During the last inspection in March 2019 we told the provider it must improve its safeguarding training completion rates. Following the inspection we raised the lack of staff who had received safeguarding training as an area of concern. The trust provided us with assurance that all staff requiring level three training would be booked onto the next available courses by November 2020.

The safeguarding team had strengthened their presence within the department since our last inspection. The team did daily walk arounds where staff could ask questions or for advice. The team had also delivered a number of different smaller training sessions in the department over the summer for different safeguarding topics to refresh staffs understanding. This was structured training with different topics delivered over a six-week period, this included topics such as child sexual exploitation and county lines training. Staff reported that this was useful and helped them to be conscious of safeguarding concerns.

The department had a lead consultant and lead nurse for safeguarding within the department, this was in line with the royal college of paediatrics and child health (RCPCH) Standards for children in emergency care settings standard 28.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were supported by a trust wide children's and adults safeguarding policy this was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 29. The safeguarding team had recently reviewed the safeguarding procedures and flow charts to make them easier for staff to understand. During the inspection we saw these displayed in the department and staff told us that they helped to strengthen the process and to make it clearer. At the time of our inspection the team were in the process of reviewing and updating the safeguarding adults policy. Staff within the department reported they were confident to report safeguarding concerns. Staff within the department were aware that when treating adults, they assessed the potential impact of a parent's or carer's physical and mental health on the wellbeing of dependents. Staff were also aware of arrangements in place to support women or children with, or at risk of Female Genital Mutilation (FGM).

The safeguarding team within the hospital had introduced safeguarding supervision. This was an hour long session that everyone within the department was required to attend at least once every six months. This was introduced to upskill staff and to give them more confidence. Staff were able to go and discuss recent cases.

The department had a pathway for staff to follow to assess the risk of physical abuse in children presenting with an injury. This had recently been strengthened and staff we spoke with were aware of the process to follow.

The department had access to the Child Protection Information Sharing System in place, this system was searched for every child who presented to the department to see if there was any information staff needed to be aware of. This was in was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 36.

All staff in the emergency department had access to safeguarding advice 24 hours a day from a paediatrician with safeguarding expertise. Staff within the department also had access 24 hours a day to a paediatric sexual assault service if they needed to make a referral or for advice. This was in was in line with the royal college of paediatrics and child health (RCPCH)standards for children in emergency care settings standard 30.

The trust had systems in place to identify children and young people who attended frequently. If a child or young person had attended more than three times in the previous year then they would be reviewed by the paediatric liaison nurse. When children visited the department their last three admissions were printed onto their records by reception staff so that staff reviewing the children could see their recent history. The trust also shared information with other trusts to help protect children who may visit multiple local hospitals. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 32.

Staff told us the primary care team, including GP and health visitor/school nurse and named social worker, were informed of each attendance. This would be completed by the paediatric liaison nurse. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 33.

The department had a standard operating procedure for when a paediatric patient either left or absconded from a department unexpectedly prior to discharge or when they did not attend for planned follow up. This included advice for staff on what to do in such event and contained contact numbers of the local safeguarding team if required. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 37.

If a child left the department unexpectedly prior to discharge then a safeguarding referral would automatically be made. This would be reviewed by the paediatric liaison nurse who would notify the relevant parties.

Staff told us that children identified as being high risk of potential safeguarding concerns were reviewed by a senior (ST4+) paediatrician or paediatric emergency medicine consultant. They would be referred to the paediatric unit in order for this to take place. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 38.

At the beginning of September 92% of staff working in the emergency department had an up to date DBS recorded.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

The urgent and emergency care department was visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed ward cleaning taking place and saw standard operating procedures about cleaning were available. ‘I am Clean’ stickers were used to indicate when equipment was ready for re-use. During the inspection we looked at cleaning records which showed that staff signed to record daily checks and cleaning had been completed.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to plentiful supplies of PPE. During the inspection we observed staff wearing the correct PPE for the area that they were working in. We saw staff consistently discarded PPE such as gloves and aprons after each patient contact and wash their hands before putting on fresh disposable PPE.

Hand cleansing gel was available at points throughout the departments for use by staff, patients and relatives and staff were ‘bare below the elbow’ to allow effective hand washing. We observed staff washing their hands between patients in line with the five moments of hand hygiene. Sinks were equipped with liquid soap, paper towels and a pedal bin to reduce cross infection. Hand gel and masks were available for patients in the entrance to the department in line with current government guidelines.

Patients were identified at streaming if they had a potential COVID-19 infection. There were two pathways through the urgent and emergency department dependent on their risk level (discussed further in environment and equipment). This helped to minimise the risk to patients of contracting COVID-19 within the department.

The service generally performed well for cleanliness. The department completed monthly infection prevention control audits. This looked at the environment, sharps, PPE, equipment, linen, waste and hand hygiene. Scores for the three months prior to our inspection were; July 89%, August 74%, September 87%.

The trust had an external audit completed in relation to their infection control measures around COVID-19 on 18 September 2020. This found the department to be compliant with national standards and did not require any follow up actions from the trust.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The adult and children's emergency departments were located together, ensuring equal access to all services, but were separated from each other. Patients self-presenting booked themselves in at reception. They were streamed by a nurse from the urgent treatment centre which was not run by the trust but was co-located. At this point patients would either be streamed to the paediatric waiting area, or the COVID-19 waiting area or non-COVID-19 waiting area. The paediatric waiting area was split from the main waiting area by a glass wall, this obscured some of the view of the main waiting area but both waiting areas were visible to each other. In the main department waiting area there were screens to separate the potential COVID-19 patients from the non-COVID-19 patients.

The department had been split into two separate streams for patients, those with potential or confirmed COVID-19 and those without any COVID-19 concerns. For the COVID-19 stream there was an ambulance triage room, a four bedded resus area which included a dedicated paediatric bed, eight cubicles for the treatment of patients. For the non- COVID-19 stream there were two triage rooms. A resuscitation area with two beds, one which could be used for paediatrics. Five high dependency beds and seven cubicles. There was also an ambulance triage area for up to six trolleys. In the paediatric department there was a triage room, one treatment room for non- COVID-19 /non-infectious children and a separate treatment and triage room for potential COVID-19 /infectious patients.

The paediatric area was small for the number of children they saw. Staff reported how they mitigated the risk by quickly triaging patients to the paediatric wards where required. They also reported how medical staff would review patients quickly in the department to reduce the amount of time they spent in the department. The paediatric waiting room had information boards, secure entry, CCTV, a TV screen and hand sanitisers. There was also a board that introduced the staff to the patients.

Staff carried out daily safety checks of specialist equipment. Regularly checked and fully equipped adult resuscitation trolleys were available in the main resuscitation area and in the non-COVID-19 resuscitation area. A fully equipped resuscitation area with all sizes of equipment was available for children and checked regularly in the COVID-19 resuscitation area and in the paediatric department. However, during the inspection, we spoke to staff in the non-COVID-19 resuscitation area who were not aware of where to find the paediatric resuscitation equipment for that area. We raised this as an area of concern with the trust during our inspection and they informed us they had spoken to staff and told them where the resuscitation equipment could be found. Sepsis trolleys were available throughout the department, this contained medicines and equipment needed to start treatment for sepsis to aid the quick treatment.

Staff carried out daily safety checks of specialist equipment. Staff working in the department reported that they had good access to equipment. During the COVID-19 outbreak the department was able to order new equipment such as heart rate monitors to ensure all bed spaces had access to one to reduce the risk of cross infection. Engineers were available to check and repair equipment where necessary. The checking of medical equipment was undertaken on a

daily basis and equipment we checked was serviced within date and marked clean for use. We checked equipment within the paediatric treatment area, this included an electrocardiogram (ECG) machine and a blood pressure monitoring machine which were both in date and due to be re-serviced in May 2021 and January 2021 respectively. The department had removed all toys from the waiting area to reduce the risk of cross-infection from COVID-19.

Staff disposed of clinical waste safely. There were effective systems and processes in place for the segregation and management of clinical and non-clinical waste. Sharps bins were readily available for staff to use.

The trust had a quiet room in the emergency department where patients could wait to have mental health assessments. It met national best practice in relation to the design and features of mental health assessment rooms: seating was sturdy and could seat four people, there was an alarm on the wall for staff to use in an emergency, there were no ligature points and two doors. The trust did not have a risk assessment for the use of the quiet room in ED. At the time of our inspection the trust was in the process of developing a psychiatric decision unit, which was going to be a room in the neighbouring urgent care centre where patients aged 16 plus could wait for a mental health assessment to be completed, this would be staffed by the trusts staff.

The trust had a ligature risk assessment for the department which identified risks in the department and how staff should manage those risks, for example, by not having high risk patients in certain cubicles.

Future building plans had been signed off and work was due to commence on a large new building to house the existing emergency department. The plans showed a large increase in floor space, an improved layout for all the areas, together with larger and wider corridors, more storage and dedicated rooms for those with additional needs. It was planned that the building work would be completed by August 2022.

**Assessing and responding to patient risk**

**Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, documentation of sepsis screening/management was not robust and required further scrutiny to ensure the safety of patients.**

Systems were in place for assessing all patients arriving in the emergency department to determine how quickly they should be reviewed. This included a clear streaming/triage process including a separate triage protocol for paediatric patients. Streaming criteria were in place for staff to determine which patients could be signposted to the co-located primary care centre. The department had a flagging system that could be used by the streaming nurse to prioritise certain patients who required a prioritised triage, this included chest pains and patients with learning disabilities whose conditions may deteriorate if they were left in the waiting area. Staff told us that whilst this may mean that certain patients had to wait longer than the target of 15 minutes for triage it helped ensure that patients were kept safe.

Experienced nurses were on duty on each shift to triage patients who self-presented in the department. Reception staff were able to quickly alert the triage nurses on duty if a patient deteriorated. Children were triaged by either a children’s nurse or a nurse who had received additional training in emergency care of the sick child.

The department had an escalation policy for when the triage time exceeded 15 minutes. This included routes for escalation and what staff should do to keep the children in the department safe. During the inspection we spoke with staff who were aware of this policy and what they would need to do if the triage time exceeded 15 minutes. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 18.

The trust conducted audits into triage times. The last paediatric audit was completed in June 2020 and looked at 10 patient records. This showed 72% were triaged within 15 minutes, 68% had a pain score completed, 88% had safeguarding risks assessed, 72% had their first set of observations within 15 minutes, 74% had PEWS completed and 96% were discharged within four hours.

# Urgent and emergency services

A live electronic feed from the local ambulance trust informed the emergency department on the arrival times of ambulances due into the department. If a seriously ill patient was being transported to the hospital they were advised prior to their arrival and could prepare in a timely way. Patients brought in by ambulance were handed over to hospital staff either in resuscitation or one of the two ambulance handover areas dependent on COVID-19 risk and how sick they were.

The trust had improved its performance on the percentage of ambulance journeys with a turnaround time of over 30 minutes. This had gone from an average of 7% January to March 2020 to an average of 1% for June to August 2020.

The NHS deems ambulance handovers delayed by more than 60 minutes as unacceptable breaches. The trust had dramatically reduced the number of breaches from 28 in January 2020, 14 in February and 30 in March to one in June, zero in July and five in August.

In the paediatric emergency department nurses in charge were either paediatric trained or adult nurses who had undertaken in-house additional training to care for children.

National Early Warning Scores (NEWS) and Paediatric Early Warning Scores (PEWS) were used throughout the emergency department to assess the deteriorating patient, particularly with regard to sepsis. NEWS uses six physiological measurements: respiratory rate; oxygen saturation; temperature; systolic blood pressure; heart rate and level of consciousness. Each scores 0–3 and individual scores are added together for an overall score. An additional two points are added if the patient is receiving oxygen therapy. The total possible score ranges from 0 to 20. The higher the score the greater the clinical risk. Higher scores indicate the need for escalation, medical review and possible clinical intervention and more intensive monitoring. PEWS scores also use six core parameters they are; respiratory rate and effort, oxygen requirements, heart rate, level of consciousness and clinician/family concern. The trust had a PEWS policy and an adult deteriorating patient escalation policy. During the inspection we looked at 11 sets of patient records, three of the adult patient records had either no NEWS completed, or no NEWS calculated.

The trust conducted monthly PEWS audits, this looked into whether the correct charts had been used, if observations had been completed and scored correctly and if required had repeated observations been completed. These audits had stopped during the peak of COVID-19 but the department had scored 100% for June, July and August 2020.

We were concerned about the way sepsis was managed in the department. During the inspection we looked at four sets of paediatric records where sepsis screening should have taken place and the pathway followed, four of which showed that the sepsis pathway had not been followed. We also looked at four sets of adult records which did not have sepsis scores/bundles completed where this would have been appropriate. Following the inspection we also looked at incidents that the department had recorded for the previous year. There were 18 reported which related to sepsis. The main themes from these incidents were delays in treatment and escalation. Eleven of these were reported as being no harm, six low harm and one moderate harm in which the patient ended up in the intensive care unit following a 151 minute delay in receiving antibiotics.

The trust completed sepsis audits as part of their monthly audit schedule, for August 2020 they had a 95% compliance rate, June they had a 96% compliance rate and May an 84% compliance rate. The trust sent their last adult emergency department sepsis screening audit from April 2020. Patients who had COVID-19 were not included within the audit. There were 33 patients who were flagged as being appropriate for sepsis screening of these 31 were screened. Four who required antibiotics were not given them within one hour.

The trust had a sepsis 2018 to 2020 flowchart document that contained recognition and assessment, immediate management, antibiotics to give further investigations and discharge and follow up.

However, during the inspection all staff we spoke with were aware of the 'Sepsis Six' and the importance of recognising sepsis in patients admitted to the department. 'Sepsis Six' are immediate interventions that increase survival from sepsis. There is strong evidence the prompt delivery of basic aspects of care detailed in the Sepsis Six care bundle prevents much more extensive damage and has been associated with significant mortality reductions when applied within the first hour.

Following the inspection, we raised sepsis management to the trust as an area of serious concern. Following discussions with ourselves and an external support organisation the trust submitted an action plan on sepsis. This included having an additional nurse in the department for the next four weeks to oversee sepsis management, escalation channels for patients with queried sepsis, improved communication around sepsis and audits to be completed to see how sepsis had been managed.

Comprehensive processes were in place for staff to follow in the event of a sudden unexpected death of a baby or child in the department. There was a pack available in the resuscitation area which explained the process, key contact details, forms that were required and blood taking equipment.

The service had 24-hour access to mental health liaison and specialist mental health support. A liaison psychiatric team staffed by mental health trained nurses, from a neighbouring mental health trust, was available to the emergency department 24 hours a day to support patients admitted with mental health problems and the staff caring for them. Any children who required a mental health assessment were admitted to the paediatric ward where they would be assessed the same day by the child and adolescent mental health (CAMHS) team. For the assessment to take place the same day a referral needed to be made by 6pm or they would be assessed the next day. In the adult department the trust had a suicidal intent assessment screening tool, this was for staff to use to asses is patients had suicidal intentions and to guide them on making a referral to the mental health team.

During the inspection we reviewed a patient record where a patient with mental health needs who was sectioned under the Mental Health Act 1983 absconded from the department. The patient records did not show where the patient was or if they were safe. This was raised on day one of the inspection and following the inspection the trust informed us that the patient was receiving appropriate care. Without us raising this patient as a concern the trust would not have been aware of what happened to this patient. The trust did have a policy for patients who had absconded. This was for staff to follow once it had been identified that a patient had gone missing from a ward area, emergency department and other areas but did not include information on what to do if a patient was detained under the Mental Health Act 1983. The trust had a separate deprivation of liberty policy.

The trust had a policy for the management of children and young people presenting to an acute service as a result of self-harm or identified mental health behaviours. This included responsibilities of different areas in the hospital and what to do in certain situations (such as if a child absconded). If a child was assessed to be at risk of suicide or self-harm, then they would be treated in the emergency department until they were medically stable then they would be transferred to the paediatric unit whilst they awaited a mental health assessment. If a child in the paediatric emergency department required extra observation, then staff from the paediatric unit who had been trained in mental health and observations would support the child in the emergency department. Staff told us that children would never be restrained in the department.

The trust did not have any procedures or policies around safe rapid tranquilisation. This could mean that staff do not have a process to follow if rapid tranquilisation if used on a patient which could result in the patient not being kept safe.

CCTV was in use in the waiting areas and corridors of the department, this was monitored 24 hours a day by the security team. Staff told us that if they were required the security team were responsive.

The trust had a policy on COVID-19 management in the emergency department, this guided staff on triage, risk factors, investigations to do, treatments and discharge. During the inspection we saw that staff followed the policy and patients were streamed, triaged and treated dependent on their risk levels.

The trust had protocols in place to transfer children who required intensive care to a neighbouring hospital. From August 2019 to July 2020 there had been no incidences where a child had been transferred from the emergency department to an intensive care unit.

Prior to our inspection we received some information that staff had been using family members to translate in the department which is against best practice guidelines. During the inspection staff told us they had access to an over the phone translation service. We also saw signs in the department in local common different languages.

**Nurse staffing**

**The service did not have enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.**

During the inspection staff reported that their main concern/risk area for the department was shortages of staff. During the inspection whilst looking at records we saw records where shortages of staff resulted in patients being put at potential risk of harm. For example, on one patient record it was recorded that triage was late due to lack of resources. We also saw two incidents where different areas of the department had to shut due to a shortage of staff, this included the cold (non- COVID19) area being shut and patients having to use the hot (COVID-19) area and one where the rapid ambulance assessment area was shut meaning patients had to be triaged elsewhere in the department.

During a review of rotas, we found shortages in the shifts filled to be in the registered nursing shifts from 10:00-21:00 (mid-shift) and 14:00-00:00 (twilight shift). From the 13 July to 06 September 2020 there were 28 out of a total 167 mid-shifts that were not filled by registered nursing staff and 41 out of 202 twilight shifts not filled. From 07 September there appeared to be improvements in staffing in the department with ten registered nursing shifts not covered across all shift times.

The service had high vacancy rates. From April 2020 to July 2020 the department had an average vacancy rate of 15.5 whole time equivalent (WTE) for registered nursing staff.

The service had high turnover rates. From April 2020 to July 2020 the trust had an average turnover rate of 20% of their total workforce.

The service had average sickness rates. From June to August the emergency department had an average sickness rate of 4.5% for their qualified nursing workforce.

The service had high rates of bank and agency nurses. From April to August 2020, 40% of total requested hours were filled by agency staff. From April to August 2020 21% of shifts were not filled by either trust, bank or agency staffing. Managers in the department told us that they tried to get agency staff who had worked in the department before and so were aware of how the department was ran.

Royal College of Paediatrics and Child Health (RCPCH) standards state that every emergency department treating children must be staffed with two registered children's nurses. From March to August 2020 there were 43 shifts that did not have two registered children's nurses on shift. The trust also told us that there had not been any moderate harm incidents over the last six months in relation to not having two children's registered nurses on each shift. The trust mitigated the risk of not having two children's nurses by having one paediatric nurse and one nurse with paediatric competencies. From 16 June to the end of September the department had 17 shifts (8% of all shifts) where the department did not have one trained paediatric nurse and one nurse with paediatric competencies which could put children at risk of being treated by a nurse who was not competent or a delay in treatment.

From March to August 2020 there were 46 incidents reported by the emergency department about sub-optimal staffing, 32 of these were reported in August 2020. Following the inspection the trust told us that all staffing incidents had been reviewed following the increase in incidents in August 2020 and found no incidents that caused any level of patient harm

and no delay in time to treat due to suboptimal staffing. However, during the inspection we reviewed one patient record and saw their triage was delayed and this was documented in the records as being related to a shortage of staffing. We also reviewed the summary of the incidents reported and these described delays in treatment for patients and increased risk of cross infection, for example having two patients in one cubicle.

Following the inspection the trust told us they have put in extra support in the department. We were told that the divisional Director of Nursing and Matron were meeting with Band 7 nurses each week for one hour to discuss any support they may require and review the staffing. They also planned to visit the emergency department on a daily basis to support the band 7 nurse in charge. They also told us that they had clear escalations in regard to staffing in place this included; lead consultant and nurse in charge have safety huddles at start of each shift (am), midday review and a late shift review. Patients in the department are reviewed and issues with flow and staffing are highlighted with clear actions to take. The trust also identified that they were working to ensure that there were two paediatric nurses on every shift and that staff were aware of escalation when this was not the case. They told us they also planned to audit the rotas.

**Medical staffing**

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction .**

The department aimed to have 20 medical staff working in the department in the week and 12 at the weekend. The trust reported an average fill rate for medical staffing from 01 April 2020 to 07 October 2020 overall as 104%. In this time period there were 24 shifts where there was one medical staff short and seven where there were two, other shifts were overstaffed reflecting the above 100 % fill rates overall. From the 10 August to 07 October there was only one shift that was missing one member of medical staff and this was due to sickness.

The service had high vacancy rates for medical staff. From April to July 2020 the emergency department had an average whole-time equivalent vacancy rate for medical staff of 18.

From June to August 2020 there was no medical staff sickness reported.

The service had high turnover rates for medical staff. From June to August 2020 the emergency department reported a 13.6% of the whole time equivalent staffing turnover rate.

The trust was unable to give us a percentage breakdown of the number of shifts filled by bank and agency medical staffing. However, they could tell us that in August 2020, 50% of required shifts were filled by either bank staff or agency staff.

The department was working to address sustainability amongst the medical workforce. They had a number of locum consultants who had joined the trust to gain experience to complete their training. The aim was that once they had completed their training, they would remain at the trust in a consultant position.

The department met the Royal College of Paediatrics and Child Health (RCPCH) standard of a dedicated paediatric emergency medicine consultant with session time allocated to paediatrics emergency department. The service had a part time consultant who had set hours spent in the department and was exploring ways that this could be increased.

**Records**

**Staff did not keep detailed records of patients’ care and treatment.**

During our inspection we found some gaps in patient records. For four paediatric patients out of the 11 records we looked at showed that the sepsis pathway was not followed correctly. Out of the 11 adult patient records we looked at;

three patients either had no national early warning score (NEWS) completed or no NEWS calculated; three patients did not have sepsis scores/bundles completed where this would have been appropriate; two patients did not have falls paperwork completed; two patients did not have venous thromboembolism (VTE) assessments completed; one patient had no observations recorded and one patient did not have a pressure ulcer assessment completed.

The trust conducted their own internal documentation audits. For the adult department they scored 72% in May, 88% in June and 96% in August 2020. For the paediatric area they scored 90% in June, 96% in July and 94% in August 2020.

During the feedback session to the trust they told us that they were aware of the gaps in the records and had action plans to address this. Following the inspection we requested these action plans. The main action in these action plans was the implementation of the electronic patient record system. The trust also had plans as part of the action plan to complete record audits to ensure they were an acceptable standard.

The trust was due to introduce an electronic patient record in the month following our inspection. Staff were optimistic that this would lead to improvements in the quality and completeness of the patient records.

When patients transferred to a new team, there were no delays in staff accessing their records. When patients were admitted to a ward or handed over to another care provider, staff undertaking and receiving the handover were required by the trust to complete a handover section found on the department's paper record for the patient. This included the patient's diagnosis, treatment plan, any safeguarding concerns and outstanding treatments. This ensured patients were not put at risk on transfer because of lack of information.

If a child or adult had previously attended the department then their records would contain details of the patient's mental health, learning disability, autism or dementia care needs alongside their physical health needs.

Discharge summaries were sent to the child's GP and other relevant healthcare professionals usually within a week of their attendance to the emergency department. This is not in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings 25 which states that discharge summaries should be send within 24 hours of their attendance.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

During the inspection staff told us that the management of controlled drugs within the emergency department had the worst performance in the hospital demonstrated by its internal audit results. There had been an incident in the department where a controlled drug went missing, despite there being an internal investigation it was not established what happened. Since June 2020 there has been a pharmacist into the emergency department full time to help improve the performance within the department. The pharmacist had conducted a review of controlled drugs management, this review showed that performance had improved since the introduction of the pharmacist into the department.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. During the inspection we were told that the medicine cabinet (an electronic lockable storage unit) that was previously used to store medications had broken in August 2020 and there had been a business case for a replacement had been submitted and it was expected they would have the new machine by January 2020. The medicines were still being stored in the medi365 but the machine was unlocked, the room the medicines were in was locked and only accessible to authorised staff.

In the resuscitation trolleys we saw appropriate emergency medicines were available. There were also appropriate medicines for the treatment of sepsis contained within the sepsis trolleys.

The trust had guidelines for staff to follow for the withdrawal of alcohol, they had plans to create guidelines for the withdrawal of illegal substances.

The department had 53 medication incidents in the last 12 months. This was six near misses, 39 no harm, seven low harm and one moderate harm. The moderate harm incident related to a patient who had diabetes and when they were admitted the ward were unable to find any documentation of blood glucose or ketones on any of the patient records.

**Incidents**

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Incidents were reported using the trusts online incident reporting system. Staff we spoke with were aware of how to report incidents and felt confident to do so. Incidents that occurred in the department were investigated by senior nursing staff and were all reviewed by the clinical director.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents and safety learning were discussed at regular weekly safety huddles. These huddles were well attended by all grades of staff, and a register was taken so that management could ascertain who had attended. During the inspection we attended one of these meetings where new incidents were discussed, and actions were chased on previously discussed incidents. There were examples where clear learning processes had been influenced and implemented following these meetings. Staff told us that incidents and learning were also discussed during handover meetings.

The trust also had monthly morbidity and mortality meetings which were attended by staff at division level. These were cancelled due to COVID-19 but recommenced in August 2020. The trust did not provide us with minutes from these. During the pandemic morbidity and mortality meetings were held at trust level but there were not any cases discussed from the emergency department at these sessions. Staff told us the learning from these meetings was shared by emails to staff who did not attend.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Following the inspection we reviewed an incident investigation. The investigations looked at root causes, any contributing factors, staff involvement and support, lessons to be learnt, examples of good practice, unrelated practice issues and action plans. They also demonstrated that duty of candour had been undertaken, through verbal telephone conversations followed up by letters.

During the inspection we were told about an incident that involved some controlled drugs going missing from the emergency department. The investigation into this incident found that incident reporting processes had not been followed fully, processes to ratify policies had not been followed so there was confusion around the policy in use at the time, confusion on staffing rotas not identifying staff members fully and poor record keeping. The trust identified an action plan which included target dates and owners for the actions, and this included keeping a pharmacist in the department to oversee medicines management until March 2021.

During the inspection there was an incident where there was a potential outbreak of COVID-19 amongst some of the reception staff in the emergency department. We saw how the trust managed this incident by stopping all non-essential visitors to the department and undertaking extra cleaning. The trust also held incident meetings where the outbreak was discussed as well as any actions that needed to take place. Following the inspection, it was highlighted that outbreaks had affected staff in three separate areas; the emergency department, therapies and the breast screening department. The trust also reported this as a serious incident internally and were conducting an investigation.

**Never Events**

The service had no never events in the department.

# Urgent and emergency services

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

From September 2019 to August 2020 there were no never events reported for urgent and emergency care.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported two serious incident (SI) in urgent and emergency care which met the reporting criteria set by NHS England from September 2019 to August 2020. The serious incidents were categorised as a fall with harm and a missed diagnosis.

The trust also reported all clinical incidents. From September 2019 to September 2020 there were 702 clinical incidents reported. 69 of these were near misses, 406 no harm, 198 low harm, 21 moderate harm, three were severe and five related to deaths. In the six months prior to our inspection there had been one child death, this was investigated, and an action plan compiled.

**Safety thermometer**

The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Safety Thermometer Data has not been submitted over the last three months. This is because all data collection for the classic safety thermometer ceased in March 2020. The trust had not collected any safety thermometer equivalent data in the previous six months to our inspection due to the pandemic

## Is the service responsive?

**Access and flow**

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line or better than national standards.**

The trust had worked to improve the accessibility and flow of the department during the pandemic. The trust were performing better than the England average for all but one of the measures we looked at.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. Patients at the trust waited on average six minutes from arrival to treatment for June 2020, less than the England average of seven minutes. *(Source: NHS Digital - A&E quality indicators)*

Managers and staff worked to make sure patients did not stay longer than they needed to. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust had worked hard to improve its performance on this measure and had increased the percentage of patients admitted under the four hour wait target from 55% in January and February 2020 to 86% in Jun and 91% in July 2020.

The departments median total time in the emergency department for admitted patients was 175 minutes, less than the England average of 214 minutes. The median total time in the emergency department for non-admitted patients was 114 minutes, less than the England average of 124 minutes, for June 2020.

The only measure that was worse than the England average was the median time between arrival time and time to be seen for treatment which was 50 minutes compared to England average of 40 minutes in June 2020.

The trust had worked to reduce the percentage of patients waiting in the department for more than six hours. This had gone from 15% in January 2020 to 4% in June, 2% in July and 4% in August.

The trust had also improved its performance on the percentage of admissions from the emergency department waiting 4-12 hours from decision to admit to admission. This had gone from 10% in February and March 2020 to less than 1% in July and 2% in August.

The number of patients leaving the service before being seen for treatments was low. In June 2020 2% of patients left the department without being seen, which was equal to the England average. Unplanned reattendances to the department within seven days was 8% at Walsall compared to the England average of 9%, in June 2020.

During the inspection we reviewed an incident where, due to a shortage of staff the ambulatory assessment area was closed. This resulted in patients being cared for in the corridor, also known as boarding. Following the inspection we asked the trust for their policy on this to see how patients would be managed safely in this area and they responded to say that boarding does not happen within the hospital.

## Is the service well-led?

**Leadership**

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The department was overseen by a clinical director and matron. At the time of our inspection there was an acting matron due to the previous matron leaving. Every member of staff we spoke with felt senior managers, including doctors, were approachable and felt well supported in their roles. Staff were supported to attend leadership courses to develop if they were new in leadership roles.

Within the trust the different departments and wards were split into divisions, the emergency department fell under the medical care division. This enabled a flow of information easily between the division due to the joint meetings that took place.

The trust had recently appointed a mental health lead nurse within the department, at the time of our inspection they had not yet started their new role.

**Vision and strategy**

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

# Urgent and emergency services

The trusts vision is: caring for Walsall together. The trust aimed for safe integrated care, delivered in partnership with social care, mental health, public health and associated charitable and community organisations. During the inspection senior staff we spoke with told us about how they worked in partnership with others and how they planned to strengthen this going forward. For example, the trusts safeguarding team had done a lot of work with the local authority to improve how they work together with the aim to improve patient safety.

The trust was also part of the Walsall Together programme that brought multi-disciplinary services such as mental health, social care and GP services together with the emergency department. This aimed to improve working relations and to provide a better service for those in the Walsall area.

The trusts values were; respect, compassion, professionalism and teamwork. These were displayed around the trust on displays for staff and visitors to see. During the inspection we saw staff display these values and staff spoke frequently about how well staff in the department worked as a team.

The trust was due to commence work on the new building to house a larger emergency department. This designed to meet the increasing demands on the department, ensure the environment was suitable for all and to increase productivity in the department. The trust held monthly meetings to discuss progress with key stakeholders. It was hoped that this new department would be finished by August 2022. To bridge the gap between the new building being completed and the current lack of space in the department the trust had funding approved for three temporary portacabins to increase the capacity of different areas within the department, for example the waiting area.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service generally had an open culture where patients, their families and staff could raise concerns without fear.**

There was a strong and palpable culture of teamwork within the emergency department and providing good quality care for patients. Staff we spoke with told us the team working in the department had been essential in supporting them through the recent pandemic.

We observed staff working well together and helping each other in an open, friendly but professional manner. Different disciplines worked alongside each other and showed respect for each other's opinions. Staff told us that everyone across the hospital worked together to enable them to provide a better service to patients.

If staff failed to perform in their job role, processes were in place to support them although staff were placed on performance management if this was necessary.

However, an incident investigation into missing controlled drugs found concerns around culture within the department. The report contributed an element of poor management of controlled drugs to the culture within emergency department around clinical challenge. This subsequently left staff unsupported during their practice to facilitate a safe environment.

Staff we spoke with told us that they were able and encouraged to report incidents. However one staff member raised that they felt that others might not be confident to report incidents due to comments from more senior staff in the department.

There were innovative approaches to help ease staffing issues, since the last inspection the department had employed four paramedics to help with the initial triage and treatment of patients. Advanced care practitioners and training nurse associates were also embedded in the department with staff reporting how well the variety in the team worked.

Staff reported that they were happy to raise concerns and were aware of the trusts freedom to speak up guardian.

There were appropriate arrangements to keep staff and others safe. There were CCTV cameras in the department which was monitored 24 hours a day by the security team. If there was an incident then staff told us the security team were responsive and would visit the department.

**Governance**

**Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

There were regular governance meetings in both the trust and the emergency department. For example, each day there were departmental huddles daily which covered different topics. There were weekly divisional safety huddle meetings. These discussed complaints, incidents, duty of candour and serious incidents. There were separate weekly divisional serious incident meetings that discussed investigations, inquests and learning. There were monthly adult and paediatric working group committees to discuss changes to policies and procedures. There was also a weekly department meeting to discuss incidents and an email was sent to all staff highlighting any themes/ concerns with the incidents each week.

The trust held monthly governance meetings with partners involved in the rapid response team. Meetings covered a variety of topics such as performance, referrals to the team, how long the team see the referrals, caseloads, risks, educational needs, new pathways, nominations for awards, operational needs of the team, infection control updates.

Individual staff we spoke with were aware of their role and responsibility, what they were accountable for and to whom.

The sepsis lead was the departments clinical director, they were supported by a team of sepsis leads who worked in the department and linked in with other sepsis leads across the hospital.

**Managing risks, issues and performance**

**Leaders and teams did not always manage performance effectively. They did not always identify and escalated relevant risks and issues and identify actions to reduce their impact. However, they had plans to cope with unexpected events.**

The trust did not always have effective performance processes in place and this had been evidenced throughout the COVID-19 pandemic. Through this period the department had paused a lot of its routine governance activities, such as audits. This meant that the senior leaders within the trust did not have a full oversight of performance within the department and therefore the safety of patients. When we raised the issues with the trust following our inspection leaders within the trust were initially unable to provide us with any assurance of how they would ensure patients were kept safe.

The department and trust did not effectively manage risks within the emergency department. Risks we found during the inspection were not always identified by staff working in the trust. When risks were identified by the trust there were gaps in the actions taken by the trust to improve performance and patient safety. For example we found that patient record completion was poor during the inspection. When we fed this back to the trust they told us that they had plans in place to improve this but when we requested these plans the main action was the implementation of a new system not how staff completion of the records would be improved.

The department had a risk register. It contained 16 risks. Nine of the risks or their associated action plans were highlighted as requiring a review. The risks with the highest ratings were; insufficient floor size of the department; failure to complete clinical documentation; ability of the paediatric service to meet the professional standards set and the lack of ability to ensure social distancing in the waiting area. The risk register contained information on the risk, controls, assurance and action plans with action owners listed. This risk register fed into the emergency department care group risk register. This risk register contained 13 risks, risks with the highest risk ratings contained on this risk register included; failure to meet national targets, inadequate data completeness, nurse staffing, reliance on locum doctors and insufficient space. This risk register was discussed at monthly care group performance meetings.

Arrangements were in place to respond to emergencies and major incidents. Comprehensive major incident and business continuity plans had been made detailing actions to be taken by different grades of staff.

The service participated in a number of audits in relation to mental health. These included, the number of patients presenting with a mental health concern, whether risk assessments of suicide had been completed and whether there were any safeguarding concerns. The service also contributed data to a number of national clinical audits which had sections for mental health data.

The trust conducted yearly nursing and medical appraisals. The completion rate for nursing staff at the time of our inspection was 44%, the department had a plan to complete appraisals by November 2020 for nursing staff. Medical staff had a completion rate of 97%.

**Managing information**

**Systems for sharing of information with external bodies were not always effective. Senior leaders in the department demonstrated they had a limited understanding of performance across the department. The information systems were integrated and secure.**

Systems for sharing of information with external bodies were not always effective. We conducted this inspection as we were unable to get assurance from the trust about some concerns that had been shared with the CQC. During the inspection the trust were slow to respond to our requests for information following our inspection visit, we requested information from the trust numerous times and had to use our powers as set out in Section 64 of the Health and Social Care Act 2008. Section 64 gives the Care Quality Commission the legal power to require certain persons to provide it with information, documents, records (including personal and medical records) or other items that the Commission considers it necessary or expedient to have for the purposes of its regulatory functions. Following the final request for information the trust shared that they recognised that they needed to ensure their data and evidence was as live and visible as possible. The trust acknowledged that data quality was a concern for them. They had two new developments to support improvements going forward; the electronic patient record system and an electronic audit tool.

Senior leaders in the department demonstrated they had a limited understanding of performance across the department. Following the inspection we requested audits form the trust, we were told these had stopped due to the COVID-19 pandemic and therefore staff had limited knowledge of performance during this period. Following our conversations with the trust they told us they planned to improve the oversight of key quality metrics by conducting a review of all key quality metrics across the organisation to identify any gaps.

Staff had access to information they needed to carry out their roles effectively, with policies and procedures available on the trust's intranet. The department used both paper and electronic records for reviewing and documenting patient care. The trust had plans to introduce an electronic patient record system in the month following our inspection. This had been communicated with staff who were excited for the new system to begin.

During our inspection we did not see any occasion when patient records with confidential information were left unattended. Patient records were kept securely at all times.

The trust used an electronic incident reporting system. During the inspection we reviewed incidents using this system, we saw an incident that had been reported that was in relation to conduct of a member of staff. This was not an appropriate incident to have on the system to protect the confidentiality of this member of staff. We raised this with the trust during our inspection and they informed us that they had removed it off the incident reporting system and the matter was being managed through their human resources processes.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.**

People who use services, those close to them and their representatives had been actively engaged and involved in decision-making for the planned new department. The trust had held focus groups to gather ideas and feedback on the new department.

Staff had also been actively engaged with the design of the new department and had attended focus groups to feed back their ideas. Staff we spoke with during the inspection spoke highly of their involvement in the new design.

The trust conducted the friends and family survey through text messages and over the phone. They had received 4,786 survey responses from September 2019 to August 2020 which included during the COVID-19 pandemic, giving an average positive score of 78.4%. Staff attitude, clinical treatment and waiting times were the top positive comment themes while staff attitude, waiting times and environment were most commented negative themes. Before the COVID-19 pandemic the trust had held weekly patient experience huddles, this involved the patient experience team playing sound bites of patient feedback to the staff in the department followed by discussions. Staff we spoke with during the inspection had said how invaluable this was to hear about the patients views first hand.

The department also had a “Star of the month” this was rewarded to a staff member for giving outstanding patient experience. Nominations were made by staff members and patient feedback was used for special mentions.

The trust had met with three patients and their families in the last 12 months following complaints.

The department held adult and paediatric steering group meetings. These were well attended by staff from the department and were used to formulate and review all standard operating procedures and policies. This gave staff the opportunity to be involved and to ensure they were relevant for the service.

Previously the department had monthly emergency department newsletters. This had stopped due to the COVID-19 outbreak and had not recommenced at the time of our inspection.

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services. The trusts focus for learning and continuous improvement lay with the new building plans.**

The trusts main focus of continuous improvement and innovation lay with the new department plans and designs. Regular meetings were being held to discuss progress and to gain new ideas with a variety of stakeholders. The trust had also put plans in place to increase the capacity within the current department to help to make sure it could meet the current demand until the new build was ready.

The trust had started work on ensuring lessons were learnt across the organisation. The department was actively involved in the trust’s improvement plan in which there was a ‘lessons learnt’ task and finish group. This commenced in August 2020 and aimed to ensure lessons from each division and care groups are shared across the organisation.

The department had also implemented regular huddles for learning. There was representation at the divisional governance sub group meeting where learning and improvement was shared. The department also met with the governance team weekly to discuss incidents. From this the clinical director of the department circulated an email to all staff highlighting any themes or areas of concerns.

The trust had also recruited to new roles; emergency care assistant practitioners and assistant care practitioners to supports rapid assessment. During the inspection we saw these roles were embedded within the department.

## Areas for improvement

**Action the provider must take to improve**

# Urgent and emergency services

**The trust must ensure:**

The provider must ensure they support staff to participate in mandatory training (regulation 18 (2)(a)).

The provider must ensure that staff are continued to be supported to complete their safeguarding training. (regulation 18(2)(a)).

The provider must ensure that risk assessments are completed for patients within the department, particularly in relation to sepsis management (regulation 12 (2)(b))

The provider must ensure they have processes in place to enable staff to safely care for patients detained under the mental health act (regulation 17 (2)(b)).

The provider must ensure they deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs (regulation 18(1).

The provider must ensure they maintain accurate, complete and contemporaneous records in respect of each service user (regulation 17 (2)(c))

The provider must ensure they evaluate and improve their practice in respect of processing information required by external bodies (regulation 17 (2)(a)).

**Action the provider should take to improve**

**The trust should ensure:**

The provider should ensure there are procedures and processes around restraint and rapid tranquilisation to make sure people are protected. (regulation 17 (2)(b)).

# Maternity

**Requires improvement**

## Summary of this service

The service has 62 maternity beds across two sites:

The Manor Hospital has 49 maternity beds, these are located within two wards and a delivery suite.

There is a consultant led delivery suite with nine rooms plus an enhanced maternity care room and an obstetric theatre, a fetal assessment unit, a triage area, induction of labour suite, outpatient antenatal clinic, antenatal/postnatal ward and a community-based midwifery service.

Elective Caesarean sections are currently performed in the elective theatres in main theatres and a Delivery Suite Theatre was opened in January 2020. There is a four-bedded transitional care unit on one of the wards.

The Freestanding Midwifery Led Unit (MLU) has three maternity beds. This was closed during our inspection so wasn't visited however has since reopened. Some community outpatient clinics took place at the MLU.

This inspection was a focussed inspection of maternity services on 8 and 9 September 2020.

We spoke to 22 staff and reviewed four prescription charts and five patient records.

We last inspected maternity services at Walsall Healthcare NHS Trust in 19 March 2019.

We rated safe as requires improvement and effective, responsive, caring and well-led as good. The overall rating for the service was good.

A range of data was requested from the service as part of this inspection.

## Is the service safe?

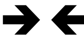
**Requires improvement**

Our rating of safe remained the same. We rated it as requires improvement because:

The service mostly controlled infection risk well.

The service mostly had suitable premises and equipment and mostly looked after them well.

## Is the service effective?

**Good** 

Our rating of effective remained the same. We rated it as good because:

The service provided care and treatment based on national guidance and evidence of its effectiveness, however not all guidelines were up to date.

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

# Maternity

## Is the service well-led?

**Requires improvement**

Our rating of well led went down one, we rated it as requires improvement because:

The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

# Detailed findings from this inspection

## Is the service safe?

**Mandatory training**

**The service provided mandatory training in key skills to all staff and made all staff completed it.**

The service dashboard identified a target of 90% for completion of mandatory training.

As of August 2020, overall compliance with midwifery mandatory training was 94% with 89% of staff having completed midwifery clinical update training.

Between February and July 2020 compliance in the ante natal clinic ranged from 81 to 87%. Community midwife compliance ranged from 85% to 87%, obstetrics and gynaecology consultant compliance ranged from 84% to 91% and obstetrics and gynaecology non consultant compliance ranged from 56% to 77%. Compliance on Ward 24 and 25 ranged from 75% to 85% and compliance on Ward 27 (delivery) ranged from 80% to 86%.

Maternity specific training covered infant feeding, perinatal mental health, ante-natal screening, K2 (Perinatal Training Programme) an interactive, online, e-learning tool, offering certification for fetal monitoring and maternity crisis management, GAP (Growth assessment Protocol) and smoking cessation. Staff accessed this training through an e learning platform.

Compliance with cardiotocography CTG training in maternity services was at 92% at the end of August 2020. This was against a trust target of compliance of 90%. cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor (EFM)

However, the antenatal and fetal assessment unit compliance was at 78% and midwife led unit at 67% (although this unit was currently closed). No action plans were provided to us. Following our inspection, the trust told us that the midwife led unit related to one member of staff. The antenatal clinic also related to one member of staff. The compliance rates were negatively affected as these were small teams with one member of staff out of date in each area.

Staff had completed training on how to reduce preventable harm for mothers and their babies. As of the end of August 2020, compliance with PROMPT (Practical Obstetric Multi-Professional Training) in maternity services was 92% against a trust target of 90%.

Staff took part in skills and drills sessions to gain and maintain the relevant skills staff required to manage a range of obstetric emergencies such as new-born basic life support, breech delivery (a breech birth occurs when a baby is born bottom first instead of headfirst), shoulder dystocia (where the infant's shoulder is obstructing labour and manipulation is required)"),

The service had a specialist continuing professional development midwife who was the lead for training and development. Their role was to support, maintain, improve and broaden staff member's knowledge and skills and develop the professional and personal qualities required in their professional lives

Staff completed their mandatory training through face-to-face sessions and online courses. Midwives and medical staff attended an update study day each year.

Managers had systems in place to monitor and address staff compliance with mandatory sent staff reminder emails in advance to inform them their training was expiring. Managers could take disciplinary action if required.

This meant staff received effective training in safety systems, processes and practices.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.**

Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff were 83% compliant with level 3 safeguarding adults and children training. All staff we spoke with had the knowledge and skills to confidently deal with safeguarding issues.

Clinical staff were required to complete level 3 in adult safeguarding with non-clinical staff completing level 2 in adult safeguarding. This covered the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom, Prevent (level 3) and the Mental Capacity Act 2005 (MCA). The MCA is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. Managers told us all staff would be compliant by November 2020 at the latest. Prevent is about safeguarding people and communities from the threat of terrorism.

Effective arrangements were in place to safeguard women from a range of risks including female genital mutilation, diabetes and epilepsy. Effective systems were in place to address areas such as child protection, asylum seekers, travellers and migrants, safeguarding unborn babies and baby abductions.

Staff could access and receive advice and support regarding safeguarding issues. For example, staff said they could contact the service wide safeguarding leads for support.

Managers identified the service were not following national guidance in relation to Safeguarding Supervision 'Working together to Safeguard Children 2015'. As a result, community midwives were unable to receive quarterly supervision around their caseload to provide shared support and learning around complex cases. Due to staffing shortages and a reduced capacity for trained supervisors there has been a significant delay in completing supervision posing a risk to patients and staff.

Managers had put action plans in place to address this such as transferring the safeguarding lead midwife into the division to provide greater access and a quarterly report had been developed to monitor all safeguarding compliance.

**Cleanliness, infection control and hygiene**

**The service mostly controlled infection risk well.**

Staff kept themselves, equipment and the premises clean. They did not always fully use control measures to prevent the spread of infection.

Although all the wards and areas we visited, were visibly clean, managers had identified issues with staff compliance with infection prevention control procedures (IPC) on the inpatient wards on the risk register. Managers had an action plan in place to address this area of risk.

For example, poor infection and prevention control standards were identified on the risk register for two areas within maternity. Audits were completed and results collated on a maternity dashboard. These showed full compliance with hand hygiene audits, 91% compliance with housekeeping audits and 86% (below expected level) for clinical audits for August 2020. Action plans had been developed to address areas of non-compliance. For example, local weekly and monthly audits were being undertaken to review the IPC standards.

Information provided by the trust identified a monthly review of infection control was undertaken and was assessed in June 2020 as clinical 84% and housekeeping 86%, July 2020 both clinical and housekeeping scored 80%, August 2020 clinical 91% and housekeeping 85%, this showed improvement on standards.

One risk register for a ward recorded a risk of infection from venous infusion phlebitis assessments (VIP) not being appropriately correctly being assessed, this was rated red and had been a risk since November 2018. Action plans were in place to address this area such as monitoring compliance monthly on the maternity metrics board VIP scoring to be undertaken three time daily for women and neonates with intravenous cannula in situ and review of compliance weekly, with monthly collation by the ward manager and matron. The trust did not provide us with these audit results. Peripheral venous catheter-associated phlebitis is caused by inflammation to the vein at a cannula access site. It can have a mechanical, chemical or infectious cause. Good practice when inserting a cannula, including appropriate choice of device and site, can help to prevent phlebitis.

Managers told us a CCG inspection in August 2020 showed full compliance and engagement of staff with IPC practices within the service.

Staff complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. All the sharps bins were dated and were not filled more than halfway.

The service adapted practices within the unit to protect patients and staff from the Covid-19 infection during the pandemic. The service enforced a two-metre social distance in the hospital and staff were asking women to attend appointments and scans alone. The sonography rooms were small and to maintain a safe social distance woman were required to attend alone. Partners were required to wait outside in the car park to ensure the antenatal clinic waiting room was also kept as clear and as safe as possible. The unit allowed one birthing partner during active labour. Staff continually monitored and reviewed these arrangements and would update our website and social media if anything changes.

Infection prevention control was audited monthly through the Midwifery Assurance System standards Tool. The tool allowed staff to self-assess whether they are meeting operational service delivery meets national standards, guidance and regulatory requirements.

We reviewed the audit results for ward 24, 25 and 27 for June, July and August 2020. In July 2020, ward 24 achieved full compliance and ward 25 achieved 91% compliance. Ward 27 achieved 84% which was below the expected standard. Areas covered included whether there was enough alcohol hand gel available at point of care and whether the 'I am clean' stickers had been appropriately used. Where staff had not fully complied with infection control standards managers immediately rectified the issue. For example, where the managers found a dirty bedpan, they cleaned it immediately.

Uniform audits looked at area such as 'are the staff bare below the elbow (no rings, bracelets etc) and 'are all staff wearing correct footwear?". Ward 24, 25 and 27 achieved full compliance for the month of June 2020. This supported what we observed.

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.**

# Maternity

The midwifery-led unit (MLU) is a short-stay birthing centre which is a relaxed environment close to the hospital with midwives and clinical support workers always on shift. At the time of our inspection the MLU was closed for deliveries, however it has since fully reopened.

Resuscitation trolleys and defibrillators were accessible to all staff in line with Resuscitation (UK) guidance.

The environmental standards ensured that women were made as comfortable and relaxed as possible throughout labour. The delivery suite offered eight functional delivery rooms, and all facilities (other than the birthing pool) could be made available for use at the time of our inspection.

The environment and housekeeping audit for delivery suite between June and August 2020 identified between 84% and 85% overall compliance. The audit identified actions undertaken such as purchase of new waste bins and replacement of sealant around sink when mould was visible.

A room was also available for women who required enhanced care in relation to their pregnancy and birth. There were two emergency theatres with round the clock access and one planned elective theatre located in the main theatre suite providing for planned C-sections two days per week.  This was increased as necessary depending on demand.

A range of birthing aids were available on the delivery suite including a birthing cube (complete with a foam mattress that allows freedom of positioning in labour), birthing pool, a specialised pole with slings/support to enable women support in labour and beanbags to aid positioning and comfort in labour

The service had systems for managing waste and clinical specimens across all locations. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.

Maternity leaders ensured the environment was comfortable for women and visitors and staff. For example, a new, improved maternity triage waiting area for mums-to-be had been created at Walsall Manor Hospital. The previous triage waiting area was situated in a corridor by the entrance doors into maternity services and women had described it as “too hot, with no windows and nowhere to really sit properly”.

The new and improved environment provided a more comfortable area for women to wait for review and assessment. This also made it easier to ensure social distancing could be maintained during the pandemic too.

Maternity care facilities were designed in keeping with the DH guidance. For example, the obstetric theatre and neonatal unit were located closely to the delivery suite.

Housekeeping was audited monthly through the Midwifery Assurance System Standards Tool. The tool allowed staff to self-assess whether their operational service delivery met national standards, guidance and regulatory requirements.

We reviewed the audit results for ward 24, 25 and 27 for June, July and August 2020. Areas covered included ‘are all high and low surfaces are free from dust?’ and ‘are chairs are free from splashes, soil, film, dust fingerprints and spillages?’. For June 2020, Ward 24 and 25 achieved 90% compliance. Ward 27 achieved 86% which was below the expected standard. Managers immediately rectified areas of non-compliance. For example, when a small amount of mould around the sinks in two rooms, the job was promptly reported for completion, at the next audit this had been resolved.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff secured and check controlled drugs in line with current national guidance and legislation. A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law. For example, two registered midwives completed the required daily checks, and all medication was in date and matched the controlled drugs register on each ward. This was in line with the Misuse of Drugs legislation.

Managers monitored medicines monthly through the matron's audit, quarterly through the pharmacy audit. This was in addition to the routine pharmacy monitoring. Compliance was escalated through the maternity inpatient forum and Nursing and Midwifery Advisory Forum through monthly metrics. Compliance for July 2020 was 93%.

Information provided by the trust for the delivery suite identified between June and August 2020 medicines audits identified between 84% and 95% compliance. The compliance was monitored monthly. The matron completed an escalation sheet which included actions for non-compliance.

Medicines were generally stored securely. However, we found an intravenous fluid (IV) cupboard was left open. Staff immediately addressed this.

Staff recorded room temperatures and escalated room temperatures that were out of range. This was in line with their policy and guidelines.

Staff had systems in place to ensure they were alerted to patients with allergies. Patients wore red wristbands detailing any allergies.

The service promoted self-care for patients. Staff could offer patients lockers for safe storage of their medications.

Ward drug storage was audited monthly through the Midwifery Assurance System Standards Tool. The tool allowed staff to self-assess whether their operational service delivery met national standards, guidance and regulatory requirements. Areas audited included 'are all medicines stored securely and appropriately are drug cupboards locked?' and 'are fridge temperature checked daily for the last 7 days?'. Ward 24, 25 and 27 achieved full compliance in this area for June 2020.

The controlled drug audit looked at areas such 'are keys to CD cupboard held by a registered Midwife?' and 'are keys kept separate from other drug keys?'. Ward 24 achieved full compliance and ward 25 and 27 achieved 89% and 87% respectively. This was below the expected standard; no action plans were provided to us.

**Records**

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

We reviewed five sets of patients records. Staff had accurately recorded the patient's choices and risk assessments and care plans were clear and up to date and signed and timed by staff.

Staff in the unit used an online portal and electronic application (app) that allowed women to access their maternity records over the internet through their PC, tablet device or mobile phone. The information that women viewed was generated in real-time from the hospital-based maternity system, using details entered by the midwife or other health professionals involved in their care. Benefits of this system included Information could be shared with women directly from the maternity system, records could be easily updated at each maternity visit or appointment, Midwives did not have to double enter data onto paper handheld notes and only those with the correct login details were able to access the notes.

Managers completed documentation audits monthly as part of the monthly metrics. Results were discussed with the deputy chief nurse. This was fed in through the nursing and midwifery advisory forum on a monthly basis. Amber and red areas were fed back to individual members of staff and fed back through Matrons assurance meetings. Information provided by the trust identified there was a monthly review called 'Maternity Assurance Standards Systems'. The assurance included the review of ten mothers and babies' records. August 2020 compliance was 95%. This was monitored on an ongoing monthly basis.

Documentation also formed part of the forward audit cycle which was undertaken annually. The overall result for this was 87% (August 2019 – October 2019). Managers produced action pans to address areas of non compliance. For example, amber and red areas were fed back to individual members of staff and fed back through matrons assurance meetings.

Whether staff stored patient case notes appropriately and not left on work surfaces/desks was audited monthly through the Midwifery Assurance System Standards Tool. The tool allowed staff to self-assess whether their operational service delivery met national standards, guidance and regulatory requirements. Ward 24, 25 and 27 achieved full compliance in this area for June 2020. This supported what we found during our inspection.

Staff ensured patients received continuity of care in the community. Staff sent discharge and care plan information to GPs upon the patients discharge from the maternity services.

**Assessing and Responding to patient risk**

**Staff completed and updated risk assessments for each patient.**

They kept clear records and asked for support when necessary.

Staff had accurately recorded the patient's choices and risk assessments and care plans were clear and up to date and signed and timed by staff in all the five records we reviewed.

Staff had the knowledge and skills to assess and respond to patients with suspected or confirmed sepsis. The services' sepsis pathway was in line with current guidance. The service had a nationally recognised sepsis screening tool. Medical and midwifery staff conducted sepsis training during their annual training day and skills and drills training. However, the guidelines for bacterial sepsis in pregnancy and the puerperium had exceeded its review date on June 2020. Following our inspection the trust told us that all non-essential meetings were cancelled between April 2020 and June 2020 due to COVID-19. This included the guidelines group. Therefore, they did not have the opportunity to review the guidelines during this period of time.

Midwives took a holistic approach to their patients and acknowledged and addressed the physiological, psychological, sociological, developmental and cultural needs of the patient. Risk assessments at booking included a social and medical assessment and referral if needed as well as consideration for mental health needs.

Patients could seek advice and treatment immediately in an urgent or emergency. Midwives ran a triage unit and could make referrals to appropriate medical professionals and others if they detected deviations from the norm.

Staff ensured high risk antenatal patients received appropriate levels of care. An antenatal lead consultant and manager triaged referrals and referred patients to the appropriate pathways.

Staff had the opportunity to share key information in a systematic and safe way. Effective handovers took place. For example, midwives, consultants, junior doctors and clinical support workers attended the daily board round. Staff held summary discussions of the patient journey and what was required that day for it to progress using the SBAR technique. SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

Staff identified and responded appropriately to changing risks to women in the unit. For example, staff were clear about the process of dealing with a patient whose condition had deteriorated. The procedure for escalation depended on the level of the problem but varied from seeking advice from managers or facilitating immediate admission to the acute department at the trust. Staff told us they could seek support from senior staff in these situations.

# Maternity

Midwives and support workers monitored vital signs for new-borns and mothers as clinically required and took time-appropriate action to prevent avoidable deterioration in a patient. Staff used the Maternal Early Warning System (MEWS) with the aim to reduce maternal morbidity and mortality and improve clinical outcomes. Managers completed audits to check whether staff had complied with these requirements.

Compliance audits with MEWS for August 2019 to October 2019 was 100% completion, this was an annual audit. The audit showed that 70% reached the required standard and 30% were suboptimal, no action plan was provided. Audits confirmed that the MEWS was documented in the record of key data staff recorded during labour.

Managers reported that consideration would be given to adding these audits to the perfect ward audits. Perfect Ward is a smartphone application for healthcare audits and assists nursing teams to monitor the quality of care. The app aims to save staff 'admin' time to give more time to patients. It also enables access to real time information.

Staff involved in surgical procedures followed a surgical safety checklist (World Health Organisation (WHO) surgical safety ('Five Steps to Safer Surgery'). Managers reviewed 10 sets of notes in maternity theatres monthly identifying full compliance with the use of the WHO checklist. Between January and July 2020, audits showed full staff compliance with the WHO checklists, these were retrospective audits of patient notes.

However, on the risk register it was identified to historic never events, it was identified that instances of poor communication and inconsistent approaches to the NaTSSiP for swab and needle counts presented a potential for incidents of women with devices in situ on ward 27. The National Safety Standards for Invasive Procedures (NatSSIPs) aim to reduce the number of patient safety incidents related to invasive procedures in which surgical never events could occur. Managers put action points in place. For example, managers were to undertake monthly spot checks in the compliance in the completion of the swab and needle checks tabs for all birth events. The aim was for staff to achieve 90% by September 2020 for all births.

Staff followed processes to assess and put the women who needed antenatal and postpartum thromboprophylaxis on the correct pathway of care. Thromboprophylaxis is a mechanical method used to treat venous thromboembolism (VTE). Venous thromboembolism (VTE) refers to a blood clot that starts in a vein. The maternity dashboard showed maternity triage compliance ranged from 97% to 98%, ward 24 showed full compliance in every month apart from July (94%), ward 25 showed 93% to 100% compliance and Ward 27 (delivery) showed 90 to 97% compliance. The national target was 95%

Safety huddles took place four times a day. These were short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care.

As part of the Midwifery Assurance System Standards Tool. Managers audited whether the Neonatal Reus had been checked daily for last 7 days and whether the Crash trolley had been checked daily for the previous months (yes 100%)

The tool allowed staff to self-assess whether their operational service delivery met national standards, guidance and regulatory requirements. Areas audited included

**Staffing**

**The service had enough nursing staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.**

The maternity inpatient service had a significant shortfall in registered midwives to support the delivery of care. Managers identified staffing issues due to an increased rate of maternity leave (25.1%) and staff shielding due to COVID-19 procedures.

# Maternity

We reviewed staffing levels for ward 24 and 25 from June to September 2020. The fill rates for registered midwives during the day ranged from 63% to 65% and for clinical support workers day fill rates ranged from 67% to 132%. The fill rate for registered midwives during the night shifts ranged from 73% to 103% and for clinical support workers from 59% to 100%.

There was a high level of maternity leave within the maternity team, currently totalling 25% of registered midwives across all inpatient areas. This included staff absence due to annual leave and time off for mandatory training.

Following our inspection the trust told us that the maternity service monitored staffing through a daily staffing huddle three times a day. The trust said high acuity may not result in the movement of staff but may result in a temporary pause of non-urgent activity. This was recorded on the acuity tool. Actions taken during these periods were recorded on the acuity notes and could be reviewed to evidence actions taken. For example, staff moved to support other areas, on-call staff called into the main maternity unit, any escalation to the manager on-call and delays in non-urgent procedures until it is was safe to proceed. However, these actions were not actively collated to gain an overview. The trust said they were looking at implementing a process so the unit could evidence the deployed staff in future.

The maternity unit Is planning to implement the acuity tool onto the postnatal area so that it can more directly support the acuity in that area.

Following the inspection, the trust told us that bed occupancy was a maximum of 62.90% during the period in question. The roster demand was not reduced when occupancy was reduced and so even if staffing were aligned to patient need there was still a reported reduced percentage fill rate.

Leaders showed an understanding of the impact of staffing levels and deployment practices and safety of care for mothers and babies. Managers identified the midwifery team having to undertake non-clinical duties due to an inability to provide 24/7 administrative support to the delivery suite as a risk on the risk register. The inability to provide twenty-four-hour ward clerk cover on delivery suite affected admissions, discharges, transfers, coding and fire safety as unaware at times of who is admitted through the electronic patient record system. Clinical Staff were required to undertake non-clinical duties in the absence of administrative support. This resulted in delays in uploading of admissions to the IT systems.

Following our inspection the trust told us there were currently 2.7 whole time equivalent (WTE) clerical staff for the ward and 3.85 WTE for delivery suite in post. The divisional directory of midwifery had recently reviewed the clerical model for the delivery suite. Using the existing budget the care group had generated round the clock cover for the delivery suite.

Additionally the care group was undertaking a ward clerk review. Following consultation with existing ward clerks the aim was to change the current provision of ward clerks and included the revision of working patterns to provide appropriate service provision.

Managers had put action plans and controls in place to address this risk. For example, a workforce and budget review was being undertaken.

It was recorded on the risk register that a shortage of sonographers could potentially lead to limited availability of scans that were required under the saving babies lives bundle. This meant there may have been an increase to the risk of not identifying babies who were small for gestational age. Following our inspection the trust told us they were mitigating this risk as the ANC met regularly with the scanning team to identify any gaps in relation to demand and put on additional lists through bank staff when required. A business case was being developed to support additional scanning capacity including midwifery sonographers

The national target to midwife to birth ratio was set nationally at 1:28. The trust achieved between 1:28 and 1:33 between February and August 2020.The trust did not meet the recommended midwife to birth ratio for six of the seven months between February and August 2020: March 2020 (1:31.9), April (1:32), May (1:29.6), June (1:33.4), July (1:32.7),

August (1:30.8). It was identified in the most recent board papers (October 2020) that “This indicator has reported red for some time. Staffing across maternity services were used flexibly to ensure women receive the expected level of support however there were ongoing staffing pressures caused by absence and vacancies. Following our inspection the trust told us staffing pressures were also impacted by high maternity leave and that the maternity unit had a live advert out to address this area of risk.

The new Birthrate+ review and recommendations have now been received by the trust and was to form part of the establishment review which is planned to be completed in September (2020)”.Birthrate plus is a tool for midwives to assess their “real time” workload in the delivery suite arising from the numbers of women needing care, and their condition on admission and during the processes of labour and delivery

The percentage of episodes appropriately staffed on labour ward as per four-hour acuity tool, ranged from 74% to 94% between March and August 2020. The trust target was 85%, this was not met on three of the months audited. The percentages showed most were near to 85% although not always meeting the target.

Critically ill women were cared for during birth. There was always at least one enhanced maternal care midwife trained midwife on duty between February and July 2020.

Women classified as being at higher obstetric or fetal risk and who may require more specialist care and input during their labour and birth were appropriately cared for. The weekly number of hours of obstetric consultant cover on the labour ward was 114 hours in every month from February to August 2020. This exceeded the national target of 98 hours.

The weekly hours of anaesthetic consultant cover on the labour ward reached the national target of 50 hours in every month from February to August 2020. This helped to ensure women received pain relief and anaesthetic choices for their labour and birth and emergencies.

The percentage of women receiving one to one care in established labour ranged from 98% to 100% from February and August 2020. The national target was 100%. This reduced the likelihood of problems for her and her baby.

The vacancy rate ranged from 25% to 42%. However, some of these figures appeared high due to a proportionally low number of staff working in some areas. For example, the vacancy rate for community midwives was two whole time equivalents WTE which had now been recruited to. There were no vacancies on delivery suite. Action plans were in place. For example, in August to September 2020 the MLU was being supported by two secondments and these positions were out to advert. The vacancy represented 2.0 whole time equivalents. Between June and August 2020, the MLU was closed. Staff were deployed as needed. Ten vacancies were kept open due to the planned closure of Foxglove ward and related to a reduction in birth numbers; this however did not account for the acuity of patients requiring care and peaks and troughs in the numbers of births. Morning staffing review huddles where staff were relocated to areas of need and the escalation policy was followed. Actions put in place included to complete a review of non-urgent activity and to identify opportunities to undertake new ways of working to support care delivery.

**Incidents**

**The service managed patient safety incidents well.**

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Since our previous inspection in 2019, the service reported no incidents which were classified as never events for maternity.

Staff understood their responsibilities to raise concerns and to record safety incidents, concerns and near misses.

Arrangements were in place to review and investigate incidents. All relevant staff, services, partner organisations and people who used services were involved in reviews and investigations. For example, incident reports made by staff were allocated to their line manager and the governance team had oversight of all incident's reports within the service. Managers reviewed all incident reports every Monday routinely. Every Tuesday an assurance working huddle was held to review all incidents, a working multi disciplinary team meeting took place every Wednesday where staff reviewed incidents that happened within the maternity unit and every Thursday a serious incident (SI) meeting was held where new SI follow ups were discussed. Lead investigators allocated by the group were always external to the maternity department.

An incident grading system was in place. If the incident was graded as level 3 or above the governance team automatically offered support. Staff defined the risk(s) in terms of the adverse consequence(s) that might arise from the risk.

Managers shared learning from lessons to make sure that action was taken to improve safety. Sharing of learning was shared across a variety of channels such as though a poster called 'incidents at a glance' and weekly safety alerts which highlighted incident themes and learning from incidents, by feeding back at handovers, huddles and team meetings and through a risk newsletter.

There had been one maternal death in the past 12 months, this was currently being investigated. Initial findings and learning had been shared with staff.

Data on incidents were presented in the form of a SPC chart, by cause, group, serious incidents, Healthcare Safety Investigation Branch cases, and concise investigations being carried out. The HSIB maternity investigation programme is part of a national action plan to make maternity care safer. Actions from incidents and updates, duty of candour monitoring was discussed. The SPC chart is known as a Statistical Process Control (SPC) chart and plots data like a run chart every week so you can see whether you are improving, if the situation is deteriorating, whether your system is likely to be capable to meet the standard, and also whether the process is reliable or variable.

A risk and incident midwife had been employed since July 2019. They reported to the divisional quality governance advisor who was also a midwife. Serious incidents (SI) were investigated by a multi-disciplinary team. Following a possible SI a tabletop discussion took place. All levels of staff were invited including junior staff. Where moderate harm or above was identified a 72-hour rapid review was carried out.

Systems were in place to ensure all incidents were graded correctly in accordance with the level of harm. For example, the risk and incident midwife reviewed all incidents every morning. This meant they could assess and carry out initial scoping if they did not agree with the rating.

We attended the divisional safety huddle meeting. All incidents level 3 of harm and above were discussed and themes were identified. Staff followed Duty of candour requirements correctly. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Staff followed the trust's duty of candour policy which set out how they would meet the legal requirements as well as promoting a culture within the organisation that encouraged candour, openness and honesty. The process was set out so that staff were supported to inform patients and their families and carers about where staff were investigating the

care they had provided to identify areas where this could be improved, provide reasonable support to them and to understand the necessity for providing truthful information and above all provide an apology to those affected. There was a duty of candour guidance pack as an appendix to the policy which offered staff useful information on all the above aspects of the process.

The patient safety teams also supported staff with the process and continued to provide bespoke individual training to colleagues where identified. The trust used a series of information leaflets, targeted towards specific patient groups (including maternity). Staff handed these to patients and families at the time verbal conversations were held. This provided information about the process which would be followed and key contact details to enable engagement throughout the following weeks. The leaflet also enabled the trust to comply with the regulation to provide in writing a summary of what was verbally discussed. The trust monitored the compliance with the application of the statutory duty of candour requirements through an electronic safeguard system, with regular assurance and monitoring of this through divisional quality governance structures and escalation to the patient safety Group.

During a governance meeting we observed staff discussing whether duty of candour had been followed up in writing for a shoulder dystocia incident. It was added to the action log that staff would follow this up in writing opportunities for shared learning were discussed

Staff also used the incident reporting system to learn from excellence (LFE). The LFE system, aimed to provide a means of identifying and capturing learning from peer-reported excellence or positive actions. For example, there were two reported within May 2020. these concerned a consultant’s safe care and high-quality delivery during a maternal cardiac arrest and positive patient experience following excellent midwifery support.

The service supported a systematic approach to the review of the loss of a fetus, neonate deaths and care complications. This helped to improve patient care and provide professional learning. The meetings gave ownership to clinical teams and offer a direct opportunity to improve care delivery in a timely manner.

Managers had processes in place to review patient deaths to ensure these did not occur due to unsafe clinical practices. The service held monthly multidisciplinary perinatal mortality and morbidity meetings, which fed into service improvement. Meetings were held locally at care group level. Any concerns were escalated through the divisional quality board. The unit was reviewing all still births for the last 18 months and had invited an external advisor to provide additional assurance.

The trust reported serious incidents relating to intrapartum still birth, early neonatal death and severe brain injury diagnosed in the first seven days of life to the Healthcare Safety Investigation Branch (HSIB). HSIB is an external investigation bureau that reviews specific maternity cases against a set criterion. Managers produced action plans to address safety recommendations made by the HSIB.

To date there were ten cases that had been referred to HSIB for consideration for their investigation. Four of these cases had been rejected by HSIB and returned to the trust to instigate further as they did not fulfil their criteria for investigation. Five of these cases were or had completed their review with HSIB. Out of these cases four were returned to the trust for factual accuracy and the final report subsequently returned to commence any actions set against recommendations. One case remained with the family for factual accuracy. Therefore, one case was currently outstanding to be completed and returned from HSIB.

Acceptance or rejection of cases to HSIB was set against a strict criteria, therefore if there was any question as to whether a case should be referred there was immediate liaison with a designated team member within HSIB to determine this.

Regardless if a case was accepted or rejected by HSIB the care group had set a standard of 72 hours to complete a rapid review of the case; this ensured that any initial learning or actions could be undertaken without delay. This has been actioned within the care group as the intention of HSIB was to return completed case reviews within a six-month period, however this timeframe had been exceeded on several occasions.

All actions noted were recorded as per routine against the relevant incident number on the trust 'safeguard' electronic system to monitor outcome and completion of actions.

Factual accuracy of a draft report returned from HSIB was checked by a designated team within the care group to ensure that the report was accurate.

Once the final report was returned to the trust the governance team within the care group along with consultant oversight determined appropriate actions against recommendations and these were duly set against the incident number on the electronic safeguard system and monitored for completion through relevant internal governance meetings.

An increase in in uterine deaths (IUD) was highlighted in the maternity governance meeting. The trust was undertaking an in depth review of all IUD cases which they would share when complete. We requested this from the trust, but the report was not yet completed. Following our inspection the trust told us the review commenced on the 23 September, 2020 and that the report would not be ready until January 2021.

**Safety Thermometer**

The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Safety Thermometer Data has not been submitted over the last three months. This is because all data collection for the adapted maternity safety thermometer ceased in March 2020. The trust had not collected any safety thermometer equivalent data in the previous six months to our inspection due to the pandemic.

## Is the service effective?

**Evidence based practice**

**The service provided care and treatment based on national guidance and evidence of its effectiveness, however not all guidelines were up to date**.

The service had consultant oversight and a designated clinical guidelines lead. They held regular multi disciplinary meetings to discuss guidelines, updates and reviews. Escalation sheets were provided to maternity governance group to ensure oversight of guidelines.

Managers checked to make sure staff followed guidance. For example, policies and procedures reflected relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), and professional bodies.

We found five of the clinical guidelines had not been updated in a timely manner. It was recorded on the risk register that many clinical guidelines and standard operating procedures were out of date. Maternity leaders were aware of this. Guidelines were monitored through the governance system. Managers had produced a guideline escalation sheet. As of July 2020, five percent of the guidelines were out of date, 8% were amber rag rated and 87% were compliant. This showed that all out-date actions were being appropriately monitored and actioned.

Staff followed evidence-based practice. For example, staff followed procedures for reducing smoking in pregnancy, women with a multiple pregnancy received additional care, staff offered women with diabetes additional or different

care to reduce associated risks and staff carried out tests so that only those women who needed prophylaxis (preventative treatments) received it, preventing unnecessary treatments. Staff offered women a choice of birth settings, antenatal care was easily and readily accessible to all pregnant women and women were supported to access antenatal care by 10 weeks. Staff treated women with respect and dignity and involved them in decisions about their own care.

Staff followed Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE-UK) (2015) guidelines. For example, staff offered all women with risk factors for gestational diabetes a tests and midwives and obstetricians emphasised the importance of fetal movements to women during antenatal appointments. We saw leaflets ‘feeling your baby move is a sign they are well’ detailing what to do if women were worried about their baby’s movements.

Staff were working towards offering patients an evidence-based bereavement pathway to improve the overall quality and consistency of bereavement care for parents and families.

**Patient Outcomes**

**Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.**

Staff collected information about the outcome of women’s care and treatment and routinely monitored this. A maternity dashboard was based on RCOG guidance, staff used the National Perinatal mortality Review Tool to review and report perinatal deaths to the required standard.

The total count of women receiving a C-section between February and July 2020 ranged from 30% to 34%. The total count of women receiving a C-section between February and July averaged at 31%. The local target was 30%. The progress was monitored weekly to show any changes, improvement or deterioration.

The number of women receiving caesarean delivery after labour had started, as well as the quite rare 'very urgently' needed Caesareans before labour (such as perhaps, after heavy vaginal bleeding), are all called 'emergency LSCS' or Category 1 or Category 2 Caesareans. The locally set target was 18%. Between February and August 2020 the trust ranged from 14.7% - 22%, for five out of six months this was worse than the local target.

The percentage of women receiving a lower (uterine) segment Caesarean section (LSCS) is the most commonly used type of Caesarean section. Most commonly to deliver the baby a transverse incision is made in the lower uterine segment above the attachment of the urinary bladder to the uterus ranged from 8% to 13%. The locally set target was 12%.

The number of vaginal delivered between February and July 2020 ranged from 58% to 64%. The national target was set at 57%.

Instrumental delivery (percentage of ventuouse and forceps) between February and July 2020 ranged from 6 to 8%. The national average was 13%.

The percentage of women who initiated breast feeding within 48 hours of birth (one month in arrears) ranged from 64% to 70% between February and July 2020. The target set by commissioners and nationally reported data was 66%.

The percentage of women receiving an induction of labour from February to July 2020 ranged from 38% to 44%. The national average was 29%.

The target for still births and set by MBRRACE was 3.7% per 1000. Between February 2020 and July 2020, the maternity department rates varied from 4.5% to 4.9% per 1000. The trust had action plans in place to address this risk. For example, we saw leaflets advising women what to do if they were worried about their babies’ movements.

Staff also provided the women with externally produced accredited midwife-led pregnancy health information for parents-to-be. The organisation funded research into the causes of pregnancy loss.

# Maternity

The target set by MBRRACE for extended perinatal mortality rate per 1000 births was 4.6% per 1000. Between February and July 2020, the maternity department rates varied between 6% and 7% per 1000.

The national average for term admissions as a percentage of registerable births (ATAIN project) was 6%. The maternity department reported between 3% and 4% between February and July 2020.

The national target for the number of shoulder dystocia's at two. The trust reported between zero and two from February to July 2020.

The percentage of episodes appropriately staffed on labour ward as per four hour acuity tool ranged between 74 and 94 % between February and May 2020. The target was 85%. No data was supplied for June and July 2020 on the maternity dashboard.

The target for one to one care in established labour ranged between 98% to 100% compliance between February and July 2020. The nationally set target was 100%.

The service had audited CTG assessment between July and September 2020, it identified between 90% and 92% compliance and for the 'fresh eyes' assessment for the same timeframe between 95% and 100% compliance.

Staff were committed to reducing the number of stillbirths, new-born and women deaths. The service took part in the 2017 MBRRACE (Maternal Newborn and Infant clinical outcome review programme (MBRRACE UK Audit) and their stabilised and risk adjusted extender perinatal mortality rate (per 1,000 births) was 4.6, the rate recorded for the unit ranged from 6 to 7 per 1000 between February and July 2020. The Stillbirth and perinatal mortality rate on the dashboard was a crude rate which tended to be slightly higher than the adjusted and stabilised rate produced by MBRRACE report.

The service had undertaken National Neonatal Audit Project (NNAP) between 2018 and 2020 to help to improve neonatal services and improve outcomes for babies dependant on maternity care for those mothers who may deliver premature babies. Information provided identified the administration of steroids and magnesium sulphate. was 100% for both in 2020 (national average 90.8% and 82.9%) Improvement was identified for presence of parents 74% during the ward round compared to a national average of 83.7%. An action plan to identify improvement was identified. Managers identified they were doing very well in a few areas but needed to work on areas such as breast feeding. Action plans had been put in place to address areas of non-compliance.

All maternity patients received safe care in the appropriate setting always. As of October 2020, the service reported no active maternity outliers.

Staff complied with procedures relating to the screening elements undertaken as part of the head-to-toe examination of the baby. The NIPE (new-born and infant physical examination) programme screens new-born babies within 72 hours of birth, and then once again between six and eight weeks for conditions relating to their heart and hips. We reviewed the NIPE compliance audit data provided to the joint Antenatal and New-born screening board meeting with NHS England and Public Health England on 09/09/2020. This audited the new-born and infant physical examination – coverage (new-born). The proportion of babies eligible for the new-born clinical physical examination who were tested within 72 hours of birth ranged from 97 to 99% compliance. the minimum target was set at no less than 95% and the target was 99.5%. Twenty-four babies did not receive their screening within 72 hours of their birth. However, eight of those babies were transfers in from other trusts after the 72-hour timeframe had elapsed. Fifteen of the babies were resident on the neonatal unit and deemed too unwell to be screened due to being ventilated. The remaining baby was resident on the postnatal ward and had their screening at seventy-four hours of age. The reason for the delay was unknown.There was no harm to this baby; the baby was under the care of the paediatricians jointly with the maternity team.

# Maternity

## Is the service well-led?

**Leadership**

**Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**

The maternity service was part of the Women's, Children's and Clinical Support Services (WCCSS) division. The interim Divisional Director of Midwifery, Gynaecology & Sexual Health and the Clinical Director led the service.

Effective leadership structures provided direction and support to staff across all areas of the unit. A Deputy Divisional Director of Midwifery, Gynaecology and Sexual Health led the service. Two community leads oversaw the four community midwifery teams.

All community and inpatient staff we spoke with said the Divisional Director of Midwifery, Gynaecology & Sexual Health, Clinical Director and matrons and area leads were visible and approachable. Staff felt leaders appreciated the day-to-day pressures they experienced. They felt supported to develop in their roles.

The labour ward had a rota of experienced senior midwives as labour shift coordinators to ensure managerial cover in line with safer childbirth guidelines. The unit had a consultant obstetrician as a clinical lead, a matron and a labour ward manager.

Leaders understood the challenges to quality and sustainability the unit faced. For example, the midwifery-led Unit had been closed and was due to re-opens for births on 5 October 2020.

Staff told us leaders were visible and approachable. They had a presence in the work area and staff felt they could approach them and discuss any issues or concerns.

**Vision and strategy for this service**

**The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.**

A five-year strategy was embedded. The service took coordinated action to address the challenges faced by its population in terms of maternal and infant health and planned to create a single Black Country maternity plan that inter-related with Birmingham and Solihull where necessary.

Staff worked with stakeholders to ensure the region had improved maternity services and outcomes based on the Better Births guidance. Service leaders had close links with maternity units and commissioners in the Black County region, this was called Local Maternity Systems (LMSs).

Staff told us felt engaged with the strategy for the service. The strategy was aligned to local plans in the wider health and social care economy and the services were planned to meet the ends of the local population. The service was committed to listening to women, their families and healthcare professionals to ensure everyone worked together to contribute, review and be involved in how services were designed and delivered as part of the local maternity system.

Key messages were shared with staff through a series of listening events. These events gave staff an opportunity to discuss what was needed within local maternity services to feel supported and listened to. It also showed that having personalised care plans and ensuring that women and their families were involved in decision making was key to ensuring they felt at the centre of their care.

**Culture**

**Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**

Staff felt supported, respected and valued and felt positive and proud to work in the unit. One member of staff described governance as very much empowering and a learning culture"

Staff felt wanted and involved in service development. For example, staff were involved in initiatives such as the introduction of the '‘perfect ward' system. This was a system of being able to record and share audits and checks in real time with colleagues.

Mechanisms were in place to provide all staff with the development they needed. Staff said they received high quality appraisal and career development conversations with managers.

Working relationships were positive all staff groups including midwives, doctors and consultants were positive. For example, staff said they felt comfortable challenging consultants if need be.

Staff felt the unit promoted a no blame culture. The culture encouraged staff to be open and honest at all levels such as with women using the service.

**Governance**

**The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.**

Effective structures, processes and systems of accountability to promote good quality services**.** Governance meetings supported the escalation of information upwards and the cascading of information from the management team to front-line staff. The service now had a specialist governance consultant

All levels of governance and management functioned effectively and interacted with each other appropriately. The divisional director of midwifery, Gynaecology and Sexual Health maintained appropriate oversight of governance in the maternity division. They attended the range of governance meetings including care group governance meetings and divisional quality meetings. These were well attended by staff from many disciplines, including obstetricians, anaesthetists and midwifery staff.

The divisional director could escalate to the trust management board and the trust board had oversight of performance within the maternity division.

Staff at all levels were clear about their roles and understood what they were accountable for and to whom. There were clear managerial lines of accountability. Registered practitioners were also registered with and accountable to regulatory bodies in terms of standards of practice and patient care. For example, midwives were professionally accountable to the Nursing and Midwifery Council (NMC).

**Management of risk, issues and performance**

**The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**

Comprehensive assurance systems were in place. We reviewed a variety of governance meeting minutes. Performance issues were appropriately escalated through clear structures and processes.

Leaders kept an overarching risk register for the maternity service. Individual departmental risk registers were also provided. The overarching risk register included 29 risks and three red risks.

The unit held regular 'risk confirm and challenge' meetings to review risk register at all levels (care group, divisional and corporate). These were discussed at the divisional quality meetings as well as the corporate risk register meetings.

Managers identified risks and these were updated regularly. Audit trails were in place to ensure that risks and issues were identified, mitigated and ultimately closed and that all actions and steps were captured.

Reviews were not always timely to ensure actions were being taken, however this may have been due to the impact of the COVID–19 epidemic.

The service had winter plans in place and managers could follow escalation procedures to keep women safe if they were up to full capacity and couldn't accept any more patients. This meant the service took potential risks into account when planning services such as the winter season and unexpected fluctuations in demand.

Leaders considered factors such as the impact on quality when making changes to the service. For example, Walsall's Midwifery Led-Unit (MLU) was set to re-open for births. This would offer women greater birth choices maternity leaders were liaising with stakeholders to ensure the re-opening of MLU did not compromise patient's safety.

**Information management**

**The service mostly collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. However systems for monitoring the provision of staffing were not robust.**

Managers demonstrated a holistic understanding of performance which looked at people's views with information on quality, operations and finance. Managers had a framework to oversee the quality and safety of patient care. They reported a range of service performance measures and discussed quality and sustainability in all governance meetings.

Arrangements ensured availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards. Staff followed the General Data Protection Regulation (GDPR).

A risk was recorded on the risk register regarding the reliability of information and data from the electronic systems used. The trust was working with the provider of the systems to resolve this.

Safety was monitored using information from a range of sources including performance against safety goals. For example, staff used a maternity dashboard. This enabled maternity clinical teams to view data collected from providers in England and regularly compare their own clinical outcomes to identify areas for quality improvement.

Leaders identified a lack of assurance around the reliability of some data systems as a risk on the risk register. As a result managers were unable to assure themselves that data which was captured and being reported on the dashboard was accurate. High quality data was important to the service as it could lead to improvements in patient care and patient safety. It also plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services. Following our inspection the trust told us this risk related specifically to breastfeeding and smoking figures. The trust told us they gained additional assurance through manual monthly audits which were carried out by the breastfeeding lead midwife and saving babies lives midwife. This was fed into the dashboard.

Although managers had systems in place to ensure safer staffing across the service such as staffing meetings and escalation processes, control measures such as redeploying midwives and using bank staff were not reflected in the fill rates reported. This meant the trust did not have an accurate picture of staffing numbers across maternity services. The trust told us they were looking at implementing a process so the service could evidence the actual numbers of staff on each shift which included deployed and bank staff.

**Engagement**

**The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**

# Maternity

People's views and experiences were gathered and acted upon to shape and improve services and culture. The patient experience Friends and Family Test (FFT) records the percentage of patients who said they would recommend the antenatal services. This was 99% in February 2020 and 100% in March 2020. The percentage of patients who said they would recommend giving birth at the unit was 100% and 98% respectively, for the post-natal ward it was 93% and 100% and the post-natal community was 99% and 97 %.the target was 95%. No figures were available for April to July 2020 due to the COVID-19 pandemic.

FFT results were presented and discussed at board level. FFT results were also included as part of the maternity dashboard so staff were aware of them.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture of the unit. The service continued to hold listening into action (LiA) events. This was a forum to engage and empower staff to make improvements that would improve the care they gave to their patients. Staff told us about the listening into action events. The purpose of LiA was to listen to staff and support them to make the changes, removing any barriers so they could take the lead and contribute to the success of their trust.

Positive and collaborative relationships were maintained with external partners. The local maternity system helped build a shared understanding of the challenges within the system and the needs of the relevant population and to deliver services to meet those needs.

**Learning, continuous improvement and innovation**

Maternity and Neonatal services at Walsall Healthcare NHS Trust were successful in the first stage of their ambition to achieve full Baby Friendly Initiative accreditation.

The Unicef UK (United Nations Children's Fund) Baby Friendly Initiative (BFI) is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. In the UK, the initiative works with health professionals to ensure that mothers and babies receive high-quality support to enable successful breastfeeding.

Walsall Healthcare was awarded its Certificate of Commitment that recognised that a healthcare facility was dedicated to implementing recognised best practice standards last year. Maternity and Neonatal Stage 1 BFI Accreditation was achieved in July.

## Areas for improvement

**Action the provider must take to improve**

**The trust must ensure:**

The trust must put in place systems or processes to effectively assess and monitor the provision of staffing within the maternity service. (regulation 17 (1)(2)(a)(b)).

# Our inspection team

**CQC team**

The team that inspected the service comprised of a CQC inspection manager, two CQC inspectors, two specialist professional advisors with experience in urgent and emergency care and maternity services. The inspection was overseen by Fiona Allinson, Head of Hospital Inspection.

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 |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing |