Walsall Healthcare NHS Trust

Quality Report

Manor Hospital
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20 – 22 June 2017 (short notice announced)
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

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 550 acute beds. There is a separate midwifery-led birthing unit and the trust's palliative care centre in Goscote is their base for a wide range of palliative care and end of life services.

Following the 2015 inspection, we rated this trust as 'inadequate'. We made judgements about eleven services across the trust as well as making judgements about the five key questions we ask. In 2015 we rated the key questions for safety, effective and well led as 'inadequate'. We rated the key questions, for caring and responsive as 'requires improvement'.

The trust was placed in special measures by the Secretary of State for Health in February 2016 following our announced comprehensive inspection on 8 to 10 September 2015 followed by three unannounced inspection visits after the announced visit on 13, 20 and 24 September 2015. We wanted to ensure services found to be providing inadequate care at the trust did not continue to do so.

After this inspection period ended, the Care Quality Commission served the trust with a Section 29a Warning Notice of the Health and Social Care Act 2008. This outlined the quality of healthcare provided by Walsall healthcare NHS Trust for the following regulated activities required significant improvement:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury

The warning notice set out the points of concern and timescales to address this and was wholly related to maternity services. The trust responded to this with a detailed plan for remedial action.

For this inspection, we undertook an unannounced inspection on 31 May 2017 where we inspected community services for adults, children and young people and end of life care. On the day of the unannounced inspection, we announced to the trust we would be returning for a short notice announced inspection on 20 to 22 June 2017. We conducted an announced visit to eight core services at Walsall Manor Hospital, which included: emergency department; medical care services; surgery; critical care; maternity; children and young people services; end of life care and out-patients and diagnostic image services. The inspection team included CQC inspectors and clinical specialist advisors for each service.

We held staff focus groups in the hospital and across community settings before and during the inspection. These included consultants, junior doctors, midwives, nurses, student nurses, healthcare assistants, administrative and clerical staff, and community staff. We also analysed data we already held about the trust to inform our inspection planning.

At this inspection, we saw improvements in ratings for all acute services at Manor Hospital with the exception of maternity and gynaecology services which remained inadequate overall and critical care which remained requires improvement overall. In the community, community health services for adults and children and young people remained at a good rating overall whilst community end of life care improved from good at our last inspection to outstanding overall.

We have rated this trust as requires improvement overall. We made judgements about eleven services across the trust as well as making judgements about the five key questions we ask. We rated the key questions for safety, effective, responsive and well led as requires improvement. We rated the key question for caring as good.

We saw several areas of good practice including:

- Staff and patients' relatives told us the dementia lead nurse for the emergency department had made significant improvements for patients living with dementia while they were being cared for in the department.

Summary of findings

- The end of life care service provided access to care and treatment in both the acute and the community settings 24-hours a day, seven days a week.
- The culture within the outpatients department had changed considerably for the better. Local staff took responsibility and ownership for their own areas and specialities.
- We saw community engagement by the Walsall Palliative Care Centre was exemplary. A panel of patients and patient relatives to reflect the needs and wishes of the local population had reviewed all the advanced care plan and the individualised care plan. A number of documents senior managers had produced had won national recognition and awards.
- The teenage pregnancy service had developed a website called 'Easy SRE', a toolkit of resources to support sex and relationships education.
- Within the community health services for children, young people and families, the speech and language therapy team, nursery nurses and transition team had been nominated for national awards.
- Within community health services for adults, an alert system had been developed to immediately notify the long-term condition teams when vulnerable adults presented in accident and emergency or any of the wards at Walsall Manor Hospital.

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

Action the hospital MUST take to improve

Maternity and Gynaecology

- Risks are explained when consenting women for procedures.
- The service uses an acuity tool to evidence safe staffing.
- Action plans are monitored and managed for serious incidents.
- Lessons are shared effectively to enable staffing learning from serious incidents, incidents and complaints.
- Staff follow best practice national guidance.

Urgent and Emergency Services

- Take action to improve ED staff's compliance with mandatory training.
- ED completes the action plan compiled following the CQC inspection carried out in September 2015.

Critical care

- Plans are in place for staff within the critical care unit to complete mandatory training. This includes appropriate levels of safeguarding training.
- All staff working within the outreach team are competent to do so.

Children and young people

- All local guidelines are updated and regularly reviewed for staff to follow.

Outpatients and Diagnostic Imaging

- Staff undertake required mandatory and safeguarding training as required for their role.
- All staff within outpatients have the required competencies to effectively care for patients, and evidence of competence is documented.
- All staff receive an appraisal in line with local policy.
- Patients medical records are kept secure at all times.
- All outpatient clinics are suitable for the purpose for which they are being used.

End of life care

- Attendance for mandatory training is improved.
- Undertake required safeguarding training as required for their individual role.
- All staff are trained and competent when administering medications via syringe driver.

Medical care

- Mandatory training is up-to-date including safeguarding training at the required level.
- There are sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep patients safe.

Surgery

- All professional staff working with children have safeguarding level 3 training.
- All staff are up-to-date with safeguarding adults.
- The safeguarding adults and safeguarding children policies are up-to-date and include relevant references to external guidance.
- Patient records are completed, that entries are legible and each entry is signed, dated with staff names and job role printed.

Summary of findings

- All shifts have the correct skill mix for wards to run safely.
- All staff are up-to-date with mandatory training.

Community Services for Children and Young People

The trust must:

- Ensure blind cords are secured in all areas where children and young people may attend.
- Ensure patient records remain confidential and stored securely.
- Continue to follow standard operating procedures with medicines in special schools.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Background to Walsall Healthcare NHS Trust

The trust provides acute hospital services from one main site, Walsall Manor Hospital and at the time of our inspection, the trust had 550 acute beds.

This trust is not a foundation trust and this inspection did therefore not form part of a foundation trust application.

Due to the special measures status of the hospital, we needed to inspect all acute and community services at the trust to determine if and where the trust had made improvements since our last inspection.

The trust board had seven Non-Executive Directors, including the Chair and two associate Non-Executive Directors. The Chief Executive Officer had been in post since May 2011.

When we inspected the trust, the Chair of the board had been in post since April 2016, the director of nursing was appointed into a permanent post in June 2016 and the director of finance had been in post since July 2015. The interim director of organisational development and human resources had only been in post for a few weeks during our announced inspection.

The trust launched their five year strategic plan in 2016 following engagement with the board, operational care groups and staff at the trust. The trust's goal for this strategy is 'becoming your partners for first class integrated care'. Delivering the trust's vision and strategic objectives was an ongoing priority for the trust.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper, Retired Medical Director, Royal Devon and Exeter NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

Inspection Manager: Angie Martin, Care Quality Commission

The inspection team also consisted of 14 acute inspectors, one medicines inspector and one medicine team support officer. 27 specialist advisors also assisted us throughout the inspection. A CQC analyst and an inspection planner also supported the inspection team throughout this inspection.

How we carried out this inspection

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

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

Before we inspected the trust, we reviewed a range of information we held about Walsall Healthcare NHS Trust. We also asked other organisations and stakeholders to share what they knew about the trust with us. These organisations included NHS Improvement, Health Education England, Walsall Healthwatch and local clinical commissioning groups.

We carried out an unannounced inspection on 31 May 2017 where we inspected community services for adults, children and young people, and end of life care. We visited the trust for a short notice announced inspection on 20 to 22 June 2017 when we inspected all acute and community services. Following this inspection, we returned to conduct unannounced inspections on 30 June 2017 and 2, 3, 4 and 6 July 2017.

Summary of findings

We held focus groups with a range of different staff including midwives, consultants, junior doctors, community staff and administrative and support staff before and during our inspection.

What people who use the trust's services say

The Friends and Family Test results for the period showed the trust scored about the same as the England average between April 2016 and March 2017. In the latest period, March 2017, the trust performance was 89% compared to an England average of 95%.

The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to cleanliness, food and facilities. In 2015, the trust performed better than the England average for privacy, dignity and wellbeing and in 2016 performance was slightly worse than the England average.

We reviewed direct patient feedback we had received before our inspection and information from stakeholders about the Manor Hospital and the services provided by the trust. We used all of this information to help direct the inspection team and focus the inspection on areas important to all service users and any areas of concern.

Facts and data about this trust

Walsall Healthcare Trust is the only provider of NHS acute care in the Walsall borough, providing inpatient and outpatient services at the Manor Hospital as well as adult, children and young people and end of life care services in the community. This trust has one acute location, Manor Hospital. It also operates from a number of community locations

The trust serves a population of approximately 270,000 people.

The health of people in Walsall is worse than the England average. Deprivation is worse than the England average and about 15,000 children live in poverty. Life expectancy for both men and women is significantly worse than the England average. Walsall has a higher than average number of teenage pregnancies within its population. Walsall ranks 33rd out of 326 local authorities for deprivation (where 1 is the most deprived and 326 is the least deprived). (Deprivation in Walsall: Summary Report, Sept 2015). Walsall had three out of seven disease and poor health indicators that were worse than the England average.

Activity

- Manor Hospital has 550 acute beds. This includes 57 maternity beds and 13 critical care adult beds. There is a separate midwifery led birthing unit and a specialist palliative care centre in the community.
- There were 4135 babies born on the delivery suite at Walsall Healthcare NHS Trust between April 2016 and March 2017 and 228 babies born at the maternity led unit.
- From April 2016 to March 2017, patients made 73,957 attendances at Walsall Manor Hospital's emergency department. Of these, 31,202 arrived by ambulance, and 14,913, or 20%, were aged 16 or under.
- Outpatient radiotherapy follow up clinics, chemotherapy services, and phlebotomy services were provided within the outpatient department. The radiology department supported the outpatient clinics as well as inpatients, emergency and GP referrals. They provided imaging for the diagnosis and interventional treatment of a number of conditions.
- Walsall Healthcare NHS Trust provides acute hospital and community an integrated palliative and end of life care service for the population of around 260,000.
- There are 356 medical inpatient beds and 24 day-case beds located across 18 wards. The trust had 33,017 medical admissions between February 2016 and January 2017. Emergency admissions accounted for

Summary of findings

17,875 (54%), 304 were elective (1%) and the remaining 14,838 (45%) were day case. Admissions for the top three specialities were general medicine (16, 881), gastroenterology (5,579) and medical oncology (3,774).

- From 1 February 2016 to 31 January 2017, the surgical services saw 2,795 elective admissions, 6,898 emergency admissions and 8,056 day admissions.
- The surgical department comprised of five surgical wards, a surgical assessment unit (SAU), a day-case unit and arrivals lounge, 11 operating theatres two of which have laminar flow and associated areas for anaesthetics and recovery. The hospital had 100 inpatient beds and 16 day-case beds. There are 27 beds on the emergency trauma and orthopaedics ward (ward 9), 14 beds on the women's emergency general surgery ward (ward 10), 25 beds on the men's emergency general surgery ward (ward 11), 16 beds on the elective trauma and orthopaedics ward (ward 20a) and 18 beds on the elective general surgery ward (ward 20b). The SAU has eight beds and six assessment chairs and the day case unit has eight beds.
- The children's wards provide care for children and young people up to and including 16 years of age. There are 36 inpatient beds/cots across the children's ward (ward 21), the paediatric assessment unit (PAU) and the neonatal unit (NNU). There is also a paediatric outpatients department (OPD) with adjacent children's orthoptic department and audiology department. The trust had 3,355 inpatient spells within children's services between February 2016 and January 2017. The most common reasons for emergency admission to children's services were respiratory infections and viral infections.
- Between May 2016 and April 2017, 9297 referrals were made to community CYP services. This included 6958 referrals to the health visiting service, 1943 referrals to the school nursing service, 9 referrals to health transition service, 92 referrals to the children's hospital at home service, and 295 referrals to the community children's nursing service (including special schools).
- Data submitted to the Intensive Care National Audit and Research Centre (ICNARC) showed that from April 2016 to March 2017, the critical care unit (CCU) at Manor Hospital had 822 admissions, excluding re-admissions.
- From October 2016 to March 2017, the CCU used 1578 bed days for level two patients, and 861 bed days were used for level three patients (a bed day is the length of stay by an admitted patient).
- Within the last two years, there has been a change towards integrated health and social care with the development of the seven integrated locality community teams for adults. The community nursing teams are co-located with community NHS staff, social care staff and mental health staff providing a service to GP practices. These teams work in partnership with acute teams, specialist teams including Rapid Response, Clinical Intervention and Intermediate Care. There were approximately 200 staff comprising of clinical and administrative staff covering an approximate caseload population of 4000 patients.
- Between April 2015 and May 2016 the trust's specialist palliative care team received 1,549 referrals. Around 65% of these patients were cancer patients and 35% had other life limiting conditions. Complementary therapies patients consisted of 84% cancer 16% non-cancer, Specialist therapies 87% cancer, 13% non-cancer. The day hospice 82% cancer 18% non-cancer and the Lymphedema service 40% cancer 60% non-cancer. The community specialist palliative care team specialised in assisting patients with conditions, which could not be cured, but in many instances, with appropriate care and interventions patients could continue to live with their condition for many years. As a result, the team had often built up close relationships with patients and their families by the time they had been identified as end of life. The service supported between 40 and 60 patients per month to die in community settings, either at home or in care homes or hospices.
- The organisation would have a deficit of £22m in 2016/17, which was much higher than the original planned deficit of £6.2m, and was in excess of the control total agreed with NHS Improvement. This was compared to a deficit of £12.9m for 2014/15.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? **We rated safe as Requires Improvement because:** • The trust had not adequately addressed the shortfall in staff since our last inspection, particularly in maternity where we were not assured the service could provide safe care and treatment to women and their babies. • We were not assured the trust had clear and robust accountability at executive and directorate level for monitoring of remedial action plans and sign off following incident investigations. This was particularly evident in maternity where we found serious incident action plans were not always monitored or completed and low harm incidents were not always categorised correctly or reviewed in a timely manner. We also found poor evidence of learning from incidents in maternity. Some senior leaders and staff in maternity did not fully understand their role and responsibility in relation to incident investigation. • During our inspection, we saw student midwives were providing one-to-one care to women in established labour whilst unsupervised. This could put women and their babies at significant risk. • We found in maternity, midwives were not following best practice when performing foetal monitoring. The documentation together with cardiotocograph (CTG) traces was not being completed in accordance with the trust's foetal monitoring guideline. • In maternity, the service was not appropriately using an acuity tool to evidence safe staffing during our inspection. • Safeguarding compliance in a number of services across the trust did not meet the trust target. We were not assured patients were protected from harm. • Mandatory training compliance across a number of services across the trust did not meet the trust target of 90%. • The trust did not procure capnographs for the critical care unit in a timely way when we highlighted insufficient numbers of capnographs during our inspection. • Throughout many services, we saw records were not always securely stored, records were not always suitable for the area of work and some services could not evidence contemporaneous record keeping.	**Requires improvement** 

Summary of findings

- The trust's pharmacy team was not able to provide a comprehensive pharmacy servicepressures on resources.
- Some staff within a number of services had not completed mandatory training in line with the requirements of their role.
- In the end of life care service, not all staff were trained and competent when administering medications via a syringe driver.

However:

- Between April 2016 and March 2017, the trust reported no incidents, which were classified as never events.
- With the exception of maternity services, lessons were effectively shared with staff across all acute and community services to enable staff learning from serious incidents, incidents, and complaints,
- The trust did not report any MRSA cases between April 2016 and March 2017.
- We saw the majority of areas we inspected throughout the trust with the exception of some areas in the antenatal clinic and early pregnancy unit, were visibly clean and free from clutter.
- We saw since our last inspection, staff had a better knowledge of the duty of candour in all departments with the exception of maternity. Staff demonstrated they fully understood the duty and processes.
- The trust's pharmacy team visited medical wards on a weekly basis to replenish stock and check medication was still in date.
- Staff across the trust, with the exception of maternity services, demonstrated a good understanding of the trust's major incident plan and knew their roles and responsibilities in the event of a major incident.
- The trust had a specially trained gynaecology consultant who could perform specialist examinations in relation to female genital mutilation if required.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency. The trust was aware of its role in relation to the duty of candour regulation introduced in November 2014. It requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. This defines specific requirements providers must follow, which includes an apology given to patients by the trust.

Summary of findings

- The trust's lead for the duty of candour was the director of nursing. The duty of candour policy described the process from triggering duty of candour through to completion, including templates for letters. Duty of candour was also included in the trust's incident reporting learning and management policy.
- The trust had a process in place to fulfil its obligations in relation to the duty of candour regulations. We reviewed the trust's electronic incident reporting form which included a section for duty of candour and verbal notification to the patient. We saw the trust's incident reporting system provided a notification when an incident of significant harm was reported. This alerted the manager that the duty of candour should be triggered.
- The trust monitored their performance regarding duty of candour compliance by reviewing data entered onto the electronic incident reporting form. This included whether a verbal apology was given, initial disclosure letter sent, final report or review provided and whether a meeting had been offered to discuss the findings. The trust also monitored and investigated where certain deadlines had not been met.
- The Divisional Governance Teams monitored each significant harm incident from reporting through to the completion of the process. This provided assistance to the clinical teams to ensure the duty was met. Each division also monitored compliance with the duty of candour at their weekly meetings. The Divisional Governance Teams conducted regular "Risk Road Shows" when they visited wards and departments to discuss patient safety including the duty of candour. Senior staff at the trust told us this contact with front line staff enabled the 'interactive sharing of key knowledge in bite size chunks.'
- We reviewed 10 serious incidents to determine if they met the duty of candour requirements. We saw in nine out of the 10 instances a letter of apology had been sent which gave a fully apology. However, in one of the letters, a consultant had not explicitly said 'sorry.' The trust assured us the final letter to the family would contain an apology and raised this with the relevant staff member to prevent reoccurrence. In addition, the head of clinical governance and each divisional quality governance advisor now reviewed each duty of candour letter before they were sent to ensure they met the requirements of the duty.
- At our previous inspection, we found frontline staff understanding of duty of candour was unclear. The trust had tried to address this by running duty of candour awareness sessions over the winter of 2016/17. We were told over 100 staff

who may be involved in duty of candour had attended these sessions. Mandatory clinical update training sessions at the trust also included information regarding the duty for the past two years as part of the patient safety section.
- During this inspection, staff knowledge of the duty of candour in all departments with the exception of maternity and gynaecology had improved since our last inspection. Staff were confident they fully understood the duty now and knew this included formal processes such as meeting with the person affected and then writing to them to apologise.
- However, the majority of staff we spoke with in maternity and gynaecology could not explain the duty of candour in any detail and were unable to describe the process involved.

Safeguarding

- The trust had a nominated executive director at board level (director of nursing) and a nominated non-executive director with responsibility for oversight of safeguarding. The director of nursing was executive lead for WHT safeguarding and was a member of the Walsall Serious Case/Strategic Incidents Committee. The senior corporate nurse for quality and safeguarding led the trust's Adult and Child Safeguarding teams and worked in partnership with Health Commissioners. The senior corporate nurse for quality and safeguarding also attended the Walsall Adult and Children's Safeguarding Boards. The trust had a dedicated safeguarding team with corporate roles and responsibilities including a Safeguarding Children Doctor and Safeguarding Adults Doctor.
- Staff knew how to report safeguarding issues and the process of safeguarding was understood and followed.
- The trust had a well- established adults and children's safeguarding committee which met every two months and was highly valued. We saw there had been a safeguarding review conducted in 2015 where 37 recommendations were made. It was recorded that all recommendations were achieved, however there was no evidence to support this.
- For 2016/17, the safeguarding children team at the trust had a total of 459 referrals: of these 123 referrals were in quarter one, 100 were in quarter two, 115 were in quarter three and 121 were in quarter four. The trust had 35 safeguarding alerts raised against them in the last 12 months. We were told senior staff produced an incident report in each instance and submitted to the relevant authorities.
- We reviewed the trust's safeguarding adult's and children's policies. All professional staff working directly with children

should be child safeguarding level three trained as per the intercollegiate document (2014). We saw not all staff working with children at the trust had completed this training and so were not trained to the required level for their role.

- The safeguarding policies were in date and the adult policy made reference to the Care Act. The policies identified lead roles with contact information. Female genital mutilation and the Mental Capacity Act (2005) were covered in separate policies.
- The trust set a target of 90% for completion of safeguarding training. As at 31 March 2017, training targets were not met for all safeguarding courses by medical staff at the trust. For example, 12 staff should have completed safeguarding children level 2 training and 42% (5 out of 12 staff) of staff had completed this training.
- Data provided by the trust before the inspection showed as of March 2017, 100% of nursing staff at the trust had completed safeguarding children levels 1 and 3 training. This exceeded the trust target of 90%. However, training targets for trust wide nursing staff were not met for safeguarding adult's levels 1, 2 and 3 and for safeguarding children level 2.
- Safeguarding training compliance was below the trust target for some safeguarding training in maternity and gynaecology compared to the trust target of 90%. Level two adult safeguarding compliance was 75.5% and 56.5% of staff had completed level 3 training. For level two children's safeguarding compliance was 58% and for level three it was 53%. This meant that babies and children may not be protected from harm due to staff not being sufficiently trained.
- However, we found the number of staff the trust identified as requiring safeguarding training at certain levels was confusing. In addition, there seemed to be a discrepancy between the recorded safeguarding training figures and the numbers of staff who have actually been trained.
- The safeguarding adults and children policies referred to the 'Prevent' strategy. This is part of the government counter-terrorism strategy designed to tackle the problem of terrorism at its roots. The adult safeguarding team was supporting this agenda. The adult safeguarding nurse was the 'Prevent' lead.
- Senior staff in ED audited records each week and these included a question regarding safeguarding. They told us education regarding domestic abuse was an area that required development at the trust.

Summary of findings

- The trust had arrangements in place to safeguard women at risk of female genital mutilation (FGM). There was a Task and Finish Group working on clinical pathways and on updating the FGM policy, which included a survivor of FGM.
- FGM formed part of both the adult and children mandatory safeguarding training which senior staff told us instructed staff regarding the reporting and referral of safeguarding when women and children were at risk of FGM. The trust was working with Walsall Safeguarding Children Board to ensure collaborative working across all agencies in relation to FGM.
- In addition, maternity staff received bespoke maternity training for FGM. A vulnerable woman midwife had recently been recruited to work alongside the safeguarding midwife to support women at risk or who had undergone FGM.
- The trust had a clinical lead for FGM who had two clinic slots for women who have undergone FGM, one antenatal and one gynaecological.

Mandatory training

- Mandatory training compliance rates were not met across a number of services across the trust, for example in ED, surgery, end of life care and medical care was not up-to-date. Mandatory training covered; conflict resolution, fire safety, infection control, equality and diversity, patient handling and information governance. With the exception of patient handling for nursing staff at 90% as of the end of March 2017, staff in ED did not meeting the trust's target for any mandatory training courses.
- Data from the trust showed that medical and nursing staff did not meet the trust target for mandatory training in most cases. For example, only 47% of medical staff had completed training on information governance and only 78% of nursing staff had completed their mandatory training on conflict resolution. Areas nursing staff did better included load handling and patient handling, which had compliance rates of above 90%.

Incidents

- Between April 2016 and March 2017, the trust reported no incidents which were classified as never events. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- The trust used an electronic incident reporting system to record, monitor and manage the investigation and documentation of all incidents at the trust.

Summary of findings

- We saw a more consistent approach to reporting and investigating incidents across all services with the exception of maternity and gynaecology since our last inspection. In maternity, serious incident action plans were not always monitored or completed. Low harm incidents were not always categorised correctly or reviewed in a timely manner. There was also poor evidence of learning from incidents.
- The governance team conducted initial case reviews for serious incidents (SIs) to establish what had happened and decided if the incident met the required threshold for a serious incident.
- SI's were reviewed at the weekly serious meeting and a report was provided to the risk management committee at each monthly meeting. Recently introduced safety huddles in each division also monitored serious incident reporting.
- In accordance with the serious incident framework 2015, the trust reported 137 serious incidents (SIs) which met the reporting criteria set by NHS England between April 2016 and March 2017. This compared to 123 incidents between May 2014 and April 2015. Pressure ulcers were the main type of SI reported.
- The trust reported 10,586 incidents to NRLS between April 2016 and May 2017. There were nine deaths reported by the trust over this period. The proportions of incidents were categorized according to severity. The largest proportion of incidents at the trust were no harm incidents of which there were 6,761 (63.9% of total incidents) during this time period. For the remainder of incidents, 3,590 (33.9%) were low harm, 180 (1.7%) were moderate harm, 46 (0.4%) were severe harm and the trust reported nine deaths (0.1%). This is consistent with other similar trusts.
- The trust used root cause analysis methodology to investigate incidents. We reviewed six investigation reports in detail to determine if the trust's investigation and response was appropriate. These included coroners 'to prevent future deaths' reports.
- We found staff to be open and transparent regarding discussions about incidents and readily shared evidence of actions taken. Interviews and observations demonstrated staff had a good knowledge of incidents and of actions required to prevent reoccurrence of incidents. All staff reported there were now improved governance arrangements in place.

Cleanliness, infection control and hygiene

- The trust had an infection prevention and control policy which we saw whilst on site.

- The trust did not report any MRSA cases between April 2016 and March 2017. Trusts have a target of preventing all MRSA infections, so the trust met this target within this period. Additionally, the trust reported 14 MSSA infections and 21 C.Difficile infections over the same period.
- We saw the majority of areas we inspected throughout the trust were visibly clean and tidy. However we saw isolated examples of poor cleanliness, for example:
  - in the antenatal clinic and early pregnancy unit there were layers of dust on top of elevated surfaces;
  - on Primrose Ward, the delivery trolley for an unexpected birth was very dusty and the emergency trolley was dirty,
  - in the emergency department resuscitation area, we found blood splashes on the arterial blood gas analyser and on a taped repair to a warm air blanket.
- We brought these concerns to the attention of senior staff during our inspection, who responded quickly to ensure these areas were cleaned.

Environment and equipment:

- During the inspection, we were concerned about the lack of the capnography equipment in the critical care unit (CCU). A capnograph is a vital piece of equipment which should be used and monitored for all patients with an artificial airway which measures how much carbon dioxide is present in a ventilated patient's breath. This helps to assess for respiratory distress, cardiac arrest and shock. We saw the service only had three machines for all patients in both the intensive care unit (ICU) and high dependency unit (HDU). CCUs should have one capnograph available for every bed in ICU, and some available (full amount varies dependant on service requirements) in HDU as a minimum. We also saw that the three available machines were not being used despite patients requiring this monitoring. Medical staff told us they had raised this issue previously however nothing had been done to provide sufficient equipment.
- Following the inspection, we were told new capnograph equipment was being trialled within CCU for potential future procurement. The trust assured us this equipment would be in place for use on the Monday following our inspection (26 June 2017). However, when we returned for an unannounced visit on 2 July 2017, staff told us there were still not enough capnographs. We were told there was one for use on HDU, and if more than one patient required this, it would be shared

between patients and cleaned in between each patient use. The trust had ordered capnographs for each bed and we saw the delivery of this equipment had arrived and was in place for each patient who required it.
- The trust had smoking stations on the grounds away from the main building. People smoked outside the windows of staff offices and staff were distressed by the pollution of air from the second hand smoke. Staff had reported this but no improvements had been implemented.

Records

- Throughout the trust, we saw records were not always securely stored and were not always suitable for the area of work.
- In outpatients, we found during clinics staff left records unattended on trolleys in the outpatient's corridor when requested to chaperone patients. This was not in line with information governance best practice, and presented a potential risk to confidential patient information being read by unauthorised persons. The services senior management team were aware of the concerns and had added to this to the departments risk register.
- In maternity, we saw medical records were not kept securely in all areas. In addition, it was difficult to have an overview of an entire patient record as some information was in the hand held notes, some on the electronic system, some in both places and sometimes it had not been recorded anywhere.This meant the maternity service was not able to recall or evidence contemporaneous record keeping when performing a review of records for complaints, incidents, or litigation.
- In surgery we found patient records were not always fully completed, entries were sometimes illegible and each entry was not always accompanied by a signature, date, printed staff name and job role.

Staffing

- We found the trust did not always have sufficient staff to meet the needs of patients across all services.
- In our previous report, we identified the trust had a staffing deficit of 321.15 WTE. During this inspection, the trust's planned staffing establishment was 4201.02 WTE and as of June 2017, there were 3882.93 WTE actual staff in post. This showed a staffing deficit across the trust of 318.09 staff and demonstrated the trust still has much to do to address this staffing deficit.

Summary of findings

- This staffing deficit was one of the main concerns highlighted in the Section 29a Warning Notice issued to the trust in 2015. During this inspection, we saw significant improvement was still required in a number of areas, such as medical and surgical services but particularly in maternity and gynaecology.
- During our inspection, we had concerns staffing levels in maternity increased the risk to women and their babies. During our unannounced inspection, the midwife-led unit (MLU) was closing overnight to support staffing on the delivery suite. Following our inspections, the MLU was also closed during the day.
- The staff group with the largest deficit was nursing and midwifery staff, band 7 and below, which had a shortfall of 130.21 (1255.44 – 1125.23) WTE. This compared to a shortfall of 110.9 WTE in our last report. Maternity and gynaecology had over 19 WTE fewer staff members than during our last inspection. The staffing data received showed the trust had not adequately addressed the staffing issues previously highlighted.
- Before and during this inspection, the trust told us they had already recruited 12 midwives to join maternity and gynaecology in August and September 2017. However, this did not mitigate against the current risks we found to women and their babies.
- In response to our concerns regarding staffing levels in maternity, we issued the trust with a letter of intent on 13 July 2017 indicating possible urgent enforcement action by way of potential use of Section 31 of the Health and Social Care Act 2008. The trust responded with an improvement action plan for maternity and outlined methods of how they were going to mitigate the staffing level risks. We requested weekly data from the trust, which they voluntarily provided. We reviewed this data in detail each week. We observed the staffing rota for the first two weeks of August 2017, which showed staffing levels had improved to achieve the staffing levels required. The service also introduced a safety huddle three times a day to review staffing in relation to the acuity of the delivery suite. We therefore gained assurance the trust were responsive to improving staffing levels in maternity to mitigate risks to women and their children.
- During our inspection, we also found nursing staffing shortages in medical and surgical services and medical care services had frequent medical rota gaps. In our previous inspection, we found a lack of paediatric trained staff in ED. During this inspection, we were told a minimum of one paediatric-trained nurse was scheduled to be on duty in ED 24 hours a day, seven

days a week. However, we saw staffing records which showed from January 2017 to April 2017 there had been no paediatric nurse on duty for 32 out of 336 shifts. Staff told us if there was no paediatric nurse on duty, children arriving in the department were streamed and triaged as normal. Staff could obtain additional support from the hospital's paediatric assessment unit or ward if necessary.

- The trust had held various recruitment events to try and address the staffing deficits at the trust. For example, the trust had conducted overseas visits to recruit registered nurses and they had recruited to 150 posts in total. However, these recruits were struggling to pass language tests and senior staff at the trust were trying to resolve this with the Nursing and Midwifery Council. In addition, the trust was now a nursing associate pilot site. The nursing associate role was a new support role that sat alongside existing healthcare support workers and fully qualified registered nurses to deliver hands-on care for patients. These staff at the trust will qualify in 2018.

Medicines

- We saw medications were prescribed appropriately for pain control and this was in line with National Institute for Health and Care Excellence (NICE) Guidelines CG140 (opioids in Palliative Care) across the majority of services at the trust.
- The trust had syringe driver devices to manage symptoms for end of life care patients', which enabled patients to have 12-hour or 24-hour continuous symptom relief. However, the trust did not ensure all end of life care staff were trained and competent to administer medications via syringe driver.
- In ED, we saw medicines management was not satisfactory in some areas of the department.
- The trust's pharmacist visited medical wards each week to check and replenish stock. However, the pharmacy team was not able to provide a comprehensive pharmacy service to ED due to pressures on resources.

Mandatory training

- In our previous report, we highlighted that mandatory training compliance was below the trust's target for some areas. The trust set a target of 90% for completion of mandatory training. The poorest compliance rates were for fire safety where 42% of staff had completed this training.

- Nursing staff assigned to the trust met training targets for equality and diversity and patient handling courses. Nursing staff at the trust failed to make training targets for conflict resolution, fire safety, infection control and information governance.
- For example, mandatory training compliance was not met in the surgery division at our last inspection. We found as at 31 March 2017, the lowest completion rate for medical staff within surgery was for information governance training at 42% and the highest completion rate was for patient handling with 83%. Therefore, the trust had still not adequately addressed this. Other areas such as ED, outpatients and diagnostic imaging, end of life care, medical services and critical care services also did not meet the trust target for mandatory training for a number of courses.

Assessing and responding to patient risk

- The trust had placed a cap of 4,200 births in place to reduce risk to women and their babies.
- When we asked staff in maternity about women receiving one-to-one care (where a qualified midwife is with them throughout established labour) between October 2016 and March 2017 this was achieved. During this inspection, to enable one-to-one care of women in established labour, student midwives told us there were many times when they were providing care unsupervised which could put women and their babies at risk. Standard 14 of the NMC 'standards for pre-registration midwifery education' states that "students undertaking pre-registration midwifery education programmes cannot be employed to provide midwifery care during their training". It sets out that these roles are supernumerary. In addition, we found midwives who were not high dependency trained caring for high-risk women. We were therefore not assured deterioration of women and babies would be identified and escalated quickly enough, putting both women and babies at risk of possible harm.
- We found in maternity, midwives were not following best practice when performing foetal monitoring and the documentation on the cardiotocograph (CTG) traces was not in accordance with the trust's foetal monitoring guideline. We observed this in six records we reviewed during our unannounced inspection. Midwives had not completed 'fresh eyes' reviews in two of the eight records we reviewed during our announced inspection. There have been three serious incidents relating to CTG and reviews to support the identification of deteriorating mothers and babies during the period October 2016 to July 2017. This was one of our concerns we raised in our

letter of intent sent to the trust post inspection. To mitigate this risk and improve CTG compliance as part of the maternity improvement action plan, the trust obtained signatures of the relevant staff who used the CTG policy to state they had read and understood the policy. By the week commencing 21 August 2017, all relevant staff had read this policy and measures had been put in place to ensure staff on annual, maternity or sick leave read the policy on their return. Following our inspection, the maternity service conducted a weekly CTG audit which formed part of the weekly data we were receiving. The latest data for the week commencing 21 August 2017 showed the hourly assessment was being completed on 90% of occasions and 2 hourly 'fresh eyes' reviews were conducted 60% of the time for this week. This was much improved from the data received from the week commencing 7 August 2017 which showed hourly assessment was completed in 25% of cases and two hourly 'fresh eyes' reviews were completed for 0% of cases this week. For the week commencing 25 September 2017, we saw these figures in both areas had reached 100%. This showed the service had made significant improvements and appropriate and thorough monitoring of CTG's was achievable.

- At the time of our inspection, we were concerned about the perceived urgency of the local escalation policy in maternity. We fed this back to the trust following our inspection and the service promptly released a revised version of the escalation policy.
- In our previous inspection in 2015, we noted that the emergency department did not have a robust process in place to assess and triage patients and some patients were not being streamed in a timely way. However, during this inspection we saw significant improvements had been made as

  the triage process was structured and thorough. Staff allocated each patient with an appropriate triage category and offered pain relief if required.
- Across medical services, we saw the trust completed audits in relation to the deteriorating patient. We reviewed the audit results between July 2016 and March 2017. The audit showed that the trust had recently improved in most areas but still had work to do. For example, in January 2017, a doctor reviewed only 41% of deteriorating patients within 30 minutes of escalation compared to 77% in March 2017. In January 2017, the frequency of compliance with observations rechecked within 60 minutes when there was a national early warning score (NEWS) of five or above was 47%, this improved to 62% in February 2017, but worsened to 57% in March 2017.

Summary of findings

- The hospital audited the management of deteriorating patients within surgery services and we reviewed audit results from April 2016 to March 2017. We saw that staff in the surgery division were failing to re-observe patients with a NEWS score above five within 60 minutes. There was a slight improvement over the year with quarter 1 (April – June) scoring 60% to quarter 4 (January – March) scoring 67%, however results were still low. The percentage of patients reviewed by a doctor within 30 minutes was also consistently low.

Major incident awareness and training

- As at 31 March 2017, 30% of staff trust wide (56 out of 188 eligible staff) had completed major incident training which was significantly below the trust target of 90%.
- Staff across the trust with the exception of maternity services demonstrated a good understanding of the trust's major incident plan. For example, staff we spoke with in the emergency department had a good understanding of their roles in a declared major incident and were aware of the hospital's major incident plan. They told us they had regular rehearsals and exercises to test their understanding and readiness. Community end of life care staff told us the trust's major incident plan had been used during periods of high demand due to winter pressures. Major incident awareness training was incorporated into the corporate update training which staff received annually. There was a major incident box in the diagnostic imaging department, with cards stating specific roles of staff in the event of a major incident
- However, staff we spoke with in maternity knew a plan existed but could not explain it in any detail or their role within the major incident plan.

Are services at this trust effective?

Requires improvement

We rated effective as Requires Improvement because:

- We saw patient care and treatment in maternity services were not providing antenatal care to women in accordance with NICE guidance.
- Maternity services did not audit the compliance of category one or category two emergency caesarean sections. This meant they were not aware if babies were put at risk due to not being delivered within the recommended time.

- Some guidelines at the trust were out-of-date and we were not assured staff were providing care in accordance with the most recent guidance. Senior management in some services had not sufficiently prioritised the updating of policies and procedures following incidents.
- We found the endoscopy unit had not achieved Joint Advisory Group (JAG) accreditation despite informing us during our last inspection this was on hold because of lack of staff capacity.
- Mental Capacity Act, 2005 (MCA) training compliance was below the trust target of 90% in maternity and gynaecology. One staff member in outpatients and diagnostic imaging had not received any training in MCA or Deprivation of Liberty Safeguards 2010 since starting at the trust 11 years ago.

However:

- The trust had good multidisciplinary working across all hospital and community services. Professionals from a variety of disciplines valued each other's contribution. There was effective team working between staff from a variety of service areas.
- Staff were well supported by DoLS champions and the older people's mental health team provided additional support with MCA and DoLS if needed.
- We found the standard of the DoLS initial assessment was good overall but if an extension was required this was often not carried out and we had concerns detained patients would no longer have a valid DoLS in place.

Evidence based care and treatment

- Staff followed best practice and guidance including NICE guidelines across the trust, with the exception of maternity services and services for children and young people.
- For example, in the end of life care service (acute) the palliative care and end of life care team leader attended Gold Standards Framework meetings with local GPs (over 90% were in the process of GSF recognition), this helped to ensure patients were receiving the best possible palliative and end of life care and support. The medical care service participated in national audits including the heart failure audit.
- Women using maternity services were not receiving antenatal care in accordance with NICE guidance. We found 11 out of 17 guidelines we reviewed in maternity were out-of-date. Two of these out-of-date guidelines related to a recent incident and remained out-of-date. We saw one of the out-of-date guidelines had been out-of-date since December 2015 and women could be at risk of further harm.

- In services for children and young people, we found 13 guidelines we reviewed were past their review date by over a year and as much as four years overdue for review. The senior management team had not prioritised guidelines despite a serious incident in October 2016.
- The trust told us one method of monitoring if clinical areas were following up-to-date policies was by senior managers and non-executive directors conducting regular quality walks. However, we were not assured this was a sufficient monitoring method as whilst reviewing the CTG electronic records in maternity we found a number of practices that were not evidence based. For example, admission CTG traces and indications for vaginal examinations were not completed in full. This was not in line with current evidence based practice (NICE care of the woman in labour 2017). Following both the announced and unannounced inspections, we were not assured the trust had robust CTG systems in place, which meant there was a serious risk to life, health and wellbeing of both mothers and babies through inadequate CTG monitoring.
- We requested compliance with CTG monitoring data following the issuing of the letter of intent. The trust conducted a weekly audit of 10 CTG samples and shared the results with us each week. The results of the audit showed poor CTG compliance. For example, week commencing 7 August 2017, 25% of hourly reviews had been completed and fresh eyes completed every 2 hours was at 0%. Fresh eyes approach is used to improve the accuracy of CTG interpretation as the tracings are viewed by more than one person. It involves two people operating together to monitor and help each other to prevent the misinterpretation on CTG tracings. The most current data received from the audit results for the week commencing 14 August 2017 showed only 22% of hourly assessments had been conducted and 44% of two hourly fresh eyes. We saw a gradual improvement with CTG monitoring data and week commencing 21 August 2017, hourly assessments audit figures had increased to 90% and fresh eyes were 60%. There was still more work required and the trust were working to improve these figures on a weekly basis.

Patient outcomes

- The trust had a mortality review process overseen by medical director in line with current best practice.
- The trust took part in the 2015 Heart Failure Audit. Results from the audit were better than the England average for all four standards relating to in-hospital care. The results were also

better in six of the seven standards relating to discharge. For example, the amount of patients that received consultant cardiologist input was 76.5%, which was better than the England average of 58.6%.

- Patient outcomes across acute and community services were varied at the trust. Some services performed better than the England average, however, we had concerns regarding maternity services who did not audit the compliance of category one emergency caesarean sections (baby should be delivered within 30 minutes of the decision), or category two emergency sections (baby should be delivered within 75 minutes of the decision). This meant they were not aware if babies were at risk due to not being delivered within the recommended time. Following inspection the service audited this in June 2017 and 74% of category one emergency caesarean sections were completed on time and 92% of category two emergency caesarean sections were completed on time. The planned caesarean section (CS) rate was consistently over the national average of 25% between 28% and 34% from October 2016 and March 2017. The emergency CS rate was above the national average at between 16% and 20%.
- In the National Laparotomy Audit 2016, the trust performed much worse than the national average at red (<50%) rating for the crude proportion of cases with pre-operative documentation of risk of death based on 106 cases.
- In the 2016 Hip Fracture Audit the trust were not meeting national standards for the proportion of patients having surgery on the day of or day after admission. The trust provided surgery for 59.3% of patients compared to the national standard of 85%.
- At our last inspection, we found the endoscopy unit did not have Joint Advisory Group (JAG) accreditation. We were told this had been deferred for six months due to staff vacancies impacting on capacity. When we returned for this inspection JAG accreditation had still not been achieved.

Multidisciplinary working

- Staff told us and we observed good multidisciplinary working across all hospital and community services. Professionals from all disciplines valued each other's contribution and there was effective team working between staff from a variety of hospital service areas.
- We saw in EOLC community multidisciplinary working was particularly good. The specialist palliative care team held daily team meetings. The awareness of patients and their individual

needs were discussed each day together with details and needs of any new patients who required visits. The team identified on a daily basis who was best able to support each patient and how care and support might best be delivered. The team liaised closely with the place nurse teams and the link nurses on each team and with therapy staff.

- Staff told us there had been improvements with the communication between CYP services and Children and Adolescent Mental Health Services (CAMHS). Regular meetings were held and staff told us they felt there was a positive working relationship. This helped with referrals and discussions about children and young people who required specialist input.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust submitted 333 Deprivation of Liberty Safeguard applications (DoLS) during 2016/17 in comparison to the 254 applications submitted during 2015/16. Nine applications were submitted from critical care areas. DoLS applications were predominately submitted from ward 4, (elderly care x 65), ward 10 (general surgery x 39) and ward 9 (trauma orthopaedic x 32). Of the total applications submitted, 31% (145), related to adults with dementia.
- Data provided by the trust showed as of 31 March 2017, Mental Capacity Act, 2005 (MCA) training was below the trust target of 90% within maternity and gynaecology as 51% of nursing staff and 33% of had completed the training. One member of staff in outpatients and diagnostic imaging told us they had not received any training in MCA or Deprivation of Liberty Safeguards 2010 since starting at the trust 11 years ago.
- We noted the trust's children's safeguarding policy did not refer to MCA for children.
- Senior staff attended more extensive MCA and DoLS training and the trust's safeguarding lead nurse trained the remainder of staff.
- The hospital had DoLs champions and had processes in place to support staff if they needed. The end of life care (acute) service had an MCA champion trophy on the ward, which and was on display to identify they had a champion for extra support if required. Staff told us they were well supported with MCA and DoLS by the older people's mental health team.
- Staff who treated children and young people were knowledgeable about the 'Gillick' competencies to assess children and young people.
- In our previous report, we stated there was a general lack of understanding about the Mental Capacity Act (MCA) and

Summary of findings

Deprivation of Liberty Safeguards (DoLS) across many of the services at the trust. During this inspection we saw staff knowledge of MCA and DoLS was generally good with the exception of maternity services and outpatients and diagnostic imaging. In ED, nurses we spoke with all demonstrated an understanding of mental capacity and the process of assessing patients. They told us they would escalate concerns about a patient's lack of mental capacity to a doctor for a them to make a decision.

- However, maternity staff we spoke with were only able to give minimal explanations of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- For the community end of life care service we saw do not attempt cardio pulmonary resuscitation (DNACPR) forms were checked during home visits and were seen to be completed correctly. Sixty four out of 73 DNACPR forms (88%) we reviewed were fully completed within the acute care setting.
- During the inspection, we reviewed DoLS paperwork for 18 patients subject to a DoLS on a number of different wards. Staff were able to identify patients subject to a DoLS on each of the wards we visited. We found the standard of the initial assessment was good overall but if an extension was required this was often not documented in the patient notes. This was the case for seven of the 18 records we reviewed and there was no evidence to indicate detained patients had a valid DoLS in place.

Are services at this trust caring?

Good

We rated caring as Good because:

- Patients and relatives were generally complimentary about staff at the trust and during our inspections we saw staff were kind, caring and compassionate across acute and community services.
- Despite the department staffing problems, we saw midwives in particular were caring and resilient and strove to achieve the best possible outcomes for women and their babies.
- Based on the results of the National Cancer Patient Experience Survey 2014/15, when asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.4. The trust was in the expected range for 38 questions , higher than expected range in one question and lower than expected in 11 questions. Patients were involved in their own care and treatment across the majority of hospital services at the trust and in particularly for end of life patients. We saw improvements had been made in ED where we had

previously highlighted patients had not been sufficiently involved in decisions about their care and treatment whilst in ED. At this inspection, patients reported staff kept them fully updated.
- Since our last inspection in 2015, the trust had employed a dedicated lead for the bereavement service to provide practical and emotional support to relatives and friends experiencing a loss.
- Patients were involved in their own care and treatment across the majority of hospital services at the trust.
- Patients received compassionate and emotional support from staff. We observed numerous respectful, reassuring and supportive interactions between staff and patients.
- The trust's chaplaincy service catered for the four main religious faiths in Walsall and could be accessed to provide emotional support to patients and their families, 24-hours a day, seven days a week.

However:

- In maternity, women, partners and families were not always involved in decisions about the woman's care and treatment. This had been highlighted at our inspection in 2015 and therefore the trust had not adequately addressed this issue.
- The maternity service did not yet have a bereavement midwife in post despite us raising this at our inspection in 2015.

Compassionate care

- We saw staff were kind, caring and compassionate across acute and community services.
- Despite the department staffing problems, we saw midwives in particular were caring and resilient. We saw midwives strove to achieve the best possible outcomes for women and their babies. However, women in maternity did not always receive compassionate care. Maternity service staff were trying to provide a caring and compassionate service in challenging circumstances.
- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England Average between April 2016 and March 2017. In the latest period, March 2017, trust performance was below the England average of 95% at 89 %.
- Based on the results of the National Cancer Patient Experience Survey 2014/15, when asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 8.4. The trust was in the expected range for 38 questions, higher than expected range in one question and

lower than expected in 11 questions. Good performing scores related to communication about free prescriptions, clear communication to patients about treatments, privacy during treatment and when discussing treatments and control of chemotherapy side effects. Poor performing scores included conflicting information given, communication to families and patient involvement in decision-making. (Source: Cancer Patient Experience Survey 2015.

- The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 in relation to cleanliness and food and facilities. In 2015, the trust performed better than the England average for privacy, dignity, wellbeing and in 2016 performance was slightly worse than the England average.
- Mortuary staff told us they worked closely with local mosques. Local mosques in the area had bought a vehicle to share within the local community and worked closely with the mortuary staff when transferring the deceased for rapid release within 24-hours for a burial.

Understanding and involvement of patients and those close to them

- Patients were involved in their own care and treatment across the majority of hospital services at the trust. This was particularly evident for end of life patients where we observed consultants and nurses communicating to a relative in a respectful and sensitive manner. They allowed their relative sufficient time to ask questions.
- However, in maternity, women, partners and families were not always involved in decisions about their care and treatment. At our previous inspection we had identified much improvement was required in maternity services to involve women in their care and treatment. Therefore, the trust had not sufficiently addressed this issue.
- At our previous inspection, we found improvements were required in ED as there had been a decline in patient involvement due to increased activity. At this inspection, patients and their relatives reported they were involved in decisions about their care and treatment throughout their time in ED. Staff had kept them informed about plans for and progress with their treatment.
- In the CQC Inpatient Survey 2015, the trust performed worse than other trusts in two of the 12 questions examined by the

CQC, about the same as other trusts for the remaining questions. The two questions with poor performance related to involving patients in decisions and staff answering questions about an operation or procedure.

Emotional support

- Patients received compassionate and emotional support from staff. We observed numerous respectful, reassuring and supportive interactions between staff and patients.
- Since our last inspection in 2015, the trust had employed a dedicated lead for the bereavement service to provide a practical and informative service together with the emotional support needed to support relatives and friends experiencing a loss. Bereavement counselling was provided by the trust from Walsall Palliative Care Centre. Two bereavement counsellors were employed, one of whom specialised in supporting children who had a parent who had passed away or was expected to pass away in the near future.
- The chaplaincy team worked closely with staff of various disciplines to meet the pastoral, spiritual and religious needs of patients, their visitor/carers and staff across the trust. The trust's chaplaincy service offered spiritual support to patients 24-hours a day, seven days a week. The service catered for the four main religious faiths in Walsall: Christianity, Muslim, Sikh, and Roman Catholic as well as supporting people of all beliefs and backgrounds. In 2016/17 the chaplaincy team supported approximately 6,000 individuals; this excluded the contacts made by volunteers.
- In ED, the trust had provided training for four members of ED staff to conduct traumatic incident debriefs.
- However, the maternity service did not have a bereavement midwife. We had identified this at our last inspection in 2015. During this inspection, we found this role had not yet been recruited to. We discussed this with the head of midwifery during our inspection who informed us this was the next specialist post the service would be recruiting for.

Are services at this trust responsive?

Requires improvement 

We rated responsive as requires improvement because:

- In ED, the department was no longer a suitable size to cope with the demands of rising patient numbers. ED did not achieve the Department of Health's standard for emergency departments of 95% of patients should be admitted, transferred or discharged within four hours of arrival in ED any month from April 2016 to March 2017.

Summary of findings

- Planning of the Maternity service was limited due to not having a full senior team in post.
- Bed occupancy for maternity at the hospital was higher than the England average and vaginal birth after caesarean clinics were having difficulty with providing appointments.
- Most antenatal clinics ran with a two hour delay and there were no displays for women and visitors to give information about how to complain.
- We saw not all departments or community services had information leaflets for patients in languages other than English.
- The length of stay for non-elective geriatric medicine was higher than the England average.
- Staff in the chemotherapy department told us that there was not always enough chairs for patients and that this affected patients waiting times.
- At the time of inspection in surgery services, there was no flagging system in use for patients living with disabilities or with hearing and sight impairments.
- We saw a lack of appropriate facilities for relatives to stay in CCU within HDU (high dependency unit) and the ICU (intensive care unit) had space for one person to stay overnight. CCU bed occupancy was consistently high throughout the reporting period.
- The environment within the CYP fracture clinic was unsuitable for children and the trust did not provide any separate waiting area for children.
- The trust did not have any dedicated beds for end of life care patients, they were cared for on general wards throughout the hospital.
- Across the outpatient department we found the majority of specialities (10 out of 18) were not meeting the national 18 week referral to treatment target for incomplete pathways of care, with urology meeting the 18 week target in 20% of cases.
- Within community CYP there were no leaflets available to provide families with the information they may require when raising concerns for example the details for the patient advice and liaison service (PALS).

However:

- Dementia training figures had improved from our previous inspection. The trust had four dementia support workers to assist patients living with dementia and their families throughout all areas of the trust.
- We saw an improvement from our last inspection in staff knowledge of the butterfly symbol.

- The trust had a free transport service for patients and relatives with limited mobility and

Service planning and delivery to meet the needs of local people

- The trust was one of three NHS trusts in the region that formed part of the Black Country Alliance (BCA). This partnership aimed to improve health outcomes, improve people's experience of healthcare and maximise the resources available so together these trusts could meet the needs of people in the Black Country community. The BCA had an agreement with a local university to
- We saw the trust identified where patient's needs were not being met and planned future service to meet the needs of local people.
- We found some premises at the trust were no longer appropriate for the services they delivered. For example, we saw in ED the department had outgrown the available space and could not cope with the increased demand it was facing. Over the next two years with the restructure of a neighbouring acute trust It was expected that demand on the service would increase further as more people will fall within Walsall ED's catchment area. Managers were sighted on these actual and potential challenges of the department. They were working with the trust board to agree a redevelopment or rebuild of the department to allow staff to provide safe, effective care for their patients.
- Since the previous CQC inspection in 2015, the trust had made significant steps towards providing a purpose built critical care unit (CCU). The trust had identified a new CCU, as the current HDU was not fit for purpose. The trust reported that this project had been in progress since before 2013. During this inspection, we saw the trust had recently commenced the building works for the new unit and it was expected to be completed by October 2018.
- The trust involved commissioners to plan services. For example, in surgery, service leaders worked alongside the healthy Walsall partnership and clinical commissioning groups (CCG) to focus on pathway development. The CCG looked at the highest and lowest referral rates and demand by speciality based on the previous year's figures and National Inflation rates.
- In the community adults service, changes to meet local demand. This included enhanced banding for posts in the continence and respiratory services, to provide additional support for patients who had recurring urinary tract and respiratory problems.

- In outpatients, we saw the therapy team (physiotherapy, occupational therapy and speech and language therapy) worked with other agencies, NHS trusts and commissioners to allow external organisations to utilise the space available within the therapy 'cluster'. For example, staff facilitated the use of rooms for community pain clinics ran by external staff.

Meeting people's individual needs

- The trust had 62 admissions of people with learning disabilities in the last year. On average, the trust had two patients with learning disabilities as inpatients at any one time. The trust was continuing to develop a work plan with IT to develop a notification to inform them when an adult with a learning disability accessed the trust.
- The trust had two acute learning disabilities liaison nurses who job shared and covered a five day period to improve the support staff could offer to people with learning disabilities.
- The trust made reasonable adjustments for people with learning disabilities and complex needs. Carers of adults with a learning disability were able to stay with them during their inpatient stay. They were able to support patients with personal care, nutrition and hydration if required. The diagnostic imaging service offered desensitisation visits to the radiography department for patients with learning disabilities. Staff told us about a patient who had previously been too frightened to have an x-ray felt reassured by this visit and was then able to have their x-ray performed.
- The trust conducted quarterly reviews of complaints and incidences regarding patients with learning disabilities to identify any key themes that need to be addressed.
- The trust had a free transporting service for patients and relatives with limited mobility.
- The trust had 802 On average, the trust had 18 severely blind or deaf inpatients at any one time. Staff told us severely blind or deaf patients were assessed as part of the nursing assessment document.
- At our last inspection in 2015, we highlighted that there was no process across the trust for staff to access interpreters for patients whose first language was not English. Staff and relatives had been used to translate which is not considered to be good practice.
- Following review in 2016, the trust had moved to a single provider of interpreting and translation services. At this inspection, staff said the translation services were easily accessible and we observed staff discussing the need for an interpreter across different services across the trust and

booking the service for a patient. British sign language (BSL) interpreters were also available if staff needed help communicating with patients who had impaired hearing. Staff at the trust could access a telephone translation service for patients, arrange for interpreters to attend the department in person if required as well as translations in a written format when requested. Data provided by the trust showed there had been an increased usage of translation services across the trust, which may have resulted from wider promotion and engagement of staff. There had been a better use of the service from community teams in particular and the top three languages requesting translation services at the trust were Punjabi, Polish and Bengali which demonstrated a population shift since 2011.

- We saw in some departments, such as ED, information leaflets were not available or obtainable in languages other than English.
- The trust has a specialist team for the care of inpatients with diabetes. They were notified of admissions for complications such as diabetic ketoacidosis and foot ulceration. The diabetes specialist nursing team, consultants or foot protection team received a referral as appropriate. The specialist nurses attended the acute medical unit each working day to identify diabetic patients via the boards.

Dementia

- The trust had 1,997 admissions of people with dementia in the last year. On average, the trust had 80 inpatients with dementia at any one time.
- The trust had a three year dementia strategy (2017 – 2020) which was currently in draft version with the aim of outlining how the trust can improve the care for patients living with dementia.
- The trust had an electronic flagging system for people with dementia within their computer system. This alert flag was available on Fusion for any adult where there was a confirmed diagnosis of dementia.
- The trust did not have a dedicated dementia ward. The majority of patients living with dementia were treated on the two elderly care wards (wards 3 and 4) and the swift discharge suite. As at March 2017, completion rates for dementia awareness training on these wards was 94% and above; this exceeded the trust target rate of 90%.
- PLACE 2016 audit score for dementia trust-wide was 77%, which was slightly worse than the England average.

Summary of findings

- The trust used 'butterfly bays' across numerous wards at the trust to denote adults who had received a formal dementia diagnosis and may need more specialised support because they were living with dementia. All staff we spoke with understood the meaning of the butterfly symbol which was an improvement from our previous inspection.
- Patients in the butterfly bay who had a cognitive impairment would have completed a "This is me" document. This would help to support the development of a therapeutic relationship between the patient and the ward staff, and the appropriate use of 'meaningful' activities specific to the needs of the patient.
- The trust did not have specialist nurse for dementia. The older people's mental health liaison team supported adults with dementia if necessary during their admission phase. There were four dementia support workers who worked at the trust and they were notified of admissions either by the wards or by the relatives and/or carers.
- Patients with dementia were assessed as part of the generic nursing and medical assessment process. The nursing team initiated the completion of the 'This is me' document by asking carers to complete it. Key things that staff considered were in relation to nutrition, environment and communication.
- Carers of adults with dementia were encouraged to support the care delivery of their loved ones whilst in hospital. This could be by the direct provision of physical care, supporting at meal times, and attending the ward if the patient was displaying any challenging behaviours. The trust's visiting policy enabled carers to have flexible visiting. It was the responsibility of staff to offer this information as part of the admission process. The dementia support workers would also promote this when they met with carers. Patients had access to out-of-hours food if required.
- Key performance indicators that were agreed as part of the trust's dementia strategy included falls assessments, nutritional assessments, use of the butterfly identifier, completion of 'This is me' document. The clinical commissioning group had undertaken joint audits with the older peoples mental health liaison team leader which addressed other care related factors such as pain management, use of pain assessment charts, appropriate use of record of behaviour charts and use of anti-psychotic medication
- As at March 2017, 97% of staff trust wide had completed dementia awareness training, against a trust target of 90%. This was much improved from our previous inspection where training figures trust wide for 2014/15 were 75.5%.

- We saw the ED dementia lead nurse was making significant improvements for patients living with dementia while they were being cared for in the department and ensured they were cared for according to their individual needs.
- We saw the trust held a dementia awareness week in May 2017. The event included hospital staff, a number of different charities and support groups with the aim of providing information and support to people living with dementia, their families and carers.

Access and flow

- The trust had an established system for monitoring the waiting times of patients, known as the referral to treatment (RTT) time.
- Between October 2016 and March 2017, the trust performed better than the England average for referral to treatment times (percentage of patients seen within 18 weeks) for admitted patients, except for December 2016. In the most recent period, March 2017, data showed 98.1% of patients were treated within 18 weeks and this was better than the England average of 89.6%.
- The trust performed around the same or worse than the national average for 18 week referral to treatment pathways in outpatients. The trust generally performed better than the national average or operational standard for those patients on urgent referral pathway (such as 62 day urgent GP referral pathway).
- Between March 2016 and February 2017, the main reasons for delayed transfer of care at the trust was completion of assessment (40.3%), followed by awaiting nursing home placement or availability (12.7%).
- At Quarter 1 2016/17 – Quarter 4 2016/17, the trust performed better than the 93% operational standard for all four quarters for people being seen within two weeks of an urgent GP referral for all cancers.
- We saw during Quarter 1 2016/17 – Quarter 4 2016/17, the trust performed better than the 96% operational standard for all four quarters for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat).
- At Quarter 1 2016/17 – Quarter 4 2016/17, the trust performed better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for the last three quarters.
- From March 2016 to September 2016, 2.6% of patients left ED before being seen for treatment. This was better than to the England average of 3.3%. However, from October 2016 to January 2017, performance against this measure was 4.4%,

which was worse than the England average of 3.1%. Overall, from March 2016 to January 2017, 3.3% of Walsall ED's patients left the department before being seen, which was similar to the England average of 3.2%.

- 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 A&E. The trust did not achieve this standard in any month from April 2016 to March 2017, and performed worse than the England average in every month from June 2016 to March 2017. The trust performed best in May 2016, when it achieved 92% against this measure, and worst in January 2017, where only 76% of patients were admitted, transferred or discharged within 4 hours. On average, from April 2016 to March 2017, the department achieved 74% against this target.
- From November 2016 to April 2017, ED did not achieve the professional quality indicator of seeing 55% of patients within an hour of their arrival. On average, only 32% of patients were assessed within this time. The department performed worst in March 2017, at 29%, and best in November 2016 at 35%.
- From November 2016 to April 2017, the department performed better than the target for 55% of patients who need to be admitted to have a decision to admit within three hours of arrival. On average, 66% of patients met this target.
- From April to June 2016 the number of patients waiting between four and 12 hours in ED from the decision to admit until being admitted was better than the England average. However, from July 2016 to March 2017 the number was worse than the England average. Performance was best in May 2016 when 7% of patients waited between four and 12 hours, and worst in January 2017, when 40% of patients waited between four and 12 hours. Performance had improved to 20% in February and March 2017 but was still worse than the England average of 14% for the same months.
- From November 2016 to April 2017, ED did not achieve the professional quality indicator of assessing 95% of patients who arrived by ambulance within 15 minutes of their arrival. On average, only 60% of patients were triaged within this time. The department performed worst in January 2017, at 51%, and best in April 2017 at 66%.
- Bed occupancy levels were generally similar to the England average for the first three quarters of 2016/17.
- The service made a joint decision with stakeholders to cap the number of births at Manor Hospital to 4200 each year. This was in response to an increase in the number of births in 2014 and

the shortage of midwives. The community midwife informed women that lived in certain geographical areas where they would birth to ensure the safety of the women accessing the Manor Hospital to give birth. As a result of the cap, we were told NNU had to open additional beds less frequently.

- The trust had a bed scheme funded by the local clinical commissioning group (CCG). This comprised of five beds at a local nursing home. These beds were reserved for patients in their last few weeks of life.

Learning from complaints and concerns

- The trust had an electronic system to record complaints, investigations and responses to complaints.
- Between April 2016 and March 2017, there were 321 complaints trust wide. The trust took an average of 42 days to investigate and close complaints. The most common category of complaint was clinical care assessment which had 190 complaints. The total number of complaints resolved was 259 and of these 40 were upheld and 58 were not upheld.
- The Divisions of Medicine and Long Term Conditions (MLTC) and Surgery generated the greatest number of complaints, accounting for 45% of all complaints received, with surgery accounting for 32% and Women's Children's and Clinical Support Services WCCS) 18%.
- During 2016/17, the over-riding theme emerging from formal complaints was 'clinical care, assessment and treatment' this accounted for 59% of all complaint categories with the following themes accounting for the majority of the rest, communication, appointments, diagnosis and discharge.
- The chief executive of the trust had overall accountability for complaints and the director of nursing was the executive lead. The chief executive and director of nursing were made aware of any significant and/or complex issues. The chief executive approved and signed all final responses to formal complaints. The chair of the Quality & Safety Committee was the non-executive lead for complaints. The head of patient relations (PALS and Complaints) was the designated manager for formal complaints, as required by the regulations, and as such had day-to-day management of the patient relations (Complaints & PALS) team.
- We saw methods of registering a comment or complaint were readily accessible at the trust. Posters and leaflets were available in all public access areas of the organisation, all health centres, advisory centres and GP surgeries in addition to the trust website. The trust aimed to resolve the majority of complaints through local resolution where possible. The head

of patient relations told us the member of staff receiving the complaint should determine if the issue is capable of being resolved promptly. If so, this member of staff would respond immediately which must include the action taken to ensure there was no reoccurrence. We were told a simple apology might be all that was required by the complainant, together with an explanation of what happened and why.

- We were told if the relevant team could not resolve a complaint locally, the patient relations team would provide additional support. Sometimes the advice of an executive was sought for more complex complaints.
- Once the final response was completed by a complaint co-ordinator, it was forwarded to the Divisional Directors for validation. Once they were satisfied answers to all the concerns were provided and relevant action outlined, it was sent back to the patient relations team. This team would conduct a final review and then forward the response to the Chief Executive for final sign off. When the Chief Executive was not available, the appointed Acting Chief Executive completed it.
- In July 2016, the trust reviewed their complaints process with a particular focus on the timeframe for responding to complaints and quality improvements. Approval for a new timeframe was agreed with local resolution targets identifying a 10, 30 and 45 working day timeframe based on agreement with the complainant and the level of seriousness afforded. The previous trust target was for 70% of all complaints to be completed within 30 working days which had only been achieved on 3 occasions in the previous 12 months 2015/16 with a mean average score overall of 51%. The changes implemented in July 2016 resulted in a steady improvement with the year - end position of 79% of all written complaints had been responded to within this timeframe.
- Learning was shared via Divisional Quality Teams and Care Groups, in addition to the Governance newsletter. Learning was also considered by the Independent Complaints Monitoring Panel. For example, in response to complaints about MRI scan waiting times, the service provided some additional capacity to report MRI scans.
- The trust conducted a feedback survey to ascertain whether complainants were satisfied with the complaints process and the overall outcome. Additionally the Complaints Monitoring Panel audited complaint responses and checked for empathy, tone and whether the response had sufficiently answered the complainants concerns.

Summary of findings

- We saw the Patient Relations Team sent complainants a feedback form to ascertain feedback if they felt the trust dealt with their complaint effectively and to help the team learn and to improve how they deal with complaints.
- The trust implemented a number of changes with the aim of improving the complaints process. Complaints investigation training was now in place for staff likely to undertake the role as an investigating officer. The trust told us this had led to an improvement in quality judged by the reduced number of cases requesting local resolution meetings and an improvement in the number of cases outstanding.
- During our short announced inspection, we reviewed 10 complaints from different directorates for both acute and community with the trust. We saw the trust demonstrated an open, honest and transparent approach to complaint investigation and strove to further improve the complaint's process. The trust responses to the complainant included evidence of thorough investigation of the areas highlighted in their original complaint. The trust demonstrated empathy, apologised to the complainant where necessary and response letters included lessons learned where necessary.
- The trust had a Complaints Monitoring Panel that was set up in October 2015 with the purpose of assisting the trust in improving complaints handling procedures and to raise standards in decision-making. Lay members led the panel with professional advice provided as and when required. The panel now had two sub-groups to focus its attention; one sub-group looked at the complaints process, and issues relating to quality. The other sub-group carried out reviews of cases, which were proving difficult to resolve where an independent review was offered. The group read the complaint letter and information from the investigation; checked that the response letter was appropriate; considered whether all the complainants' questions had been answered and whether there was evidence that changes have been made in the trust. The group also shared learning and improvements from the complaints received such as doctors needing to listen and take on board what patients, relatives and GP's said about a patient's history.
- The trust worked with a department store to use their model of customer care programme to improve their complaints process. Staff volunteered to be customer care champions who could train other staff in their departments.

Are services at this trust well-led?
We rated well-led as Requires Improvement because

Requires improvement

- The trust's executive board did not have complete oversight into the potential risks to mothers and their babies despite us identifying this at our previous 2015 inspection.
- The trust had failed to adequately address the bullying culture, particularly in maternity despite this being raised at our previous inspection and forming part of the warning notice in 2015.
- One senior consultant in maternity refused to follow the trust's guidelines, which was indicative of the blocking culture to improvement in maternity.
- The organisation would have a deficit of £22m in 2016/17, which was much higher than the original planned deficit of £6.2m, and was in excess of the control total agreed with NHS Improvement. This was compared to a deficit of £12.9m for 2014/15.
- The corporate risk register did not fully represent the full extent of the key risks to the trust

However:

- Senior executives at the trust understood their roles and responsibilities**.**
- The trust had a clear management structure and staff reported the executive team and managers were visible, approachable, and supportive.
- The trust had appointed divisional directors to support the clinically led model. Each service now wanted to own and make improvements in their own service.
- Staff understood the trust's priorities and challenges it faced and were engaged with the trust's vision.
- Staff told us the trust was on an improvement journey and they realised there was still much to do but had a clear idea of where they were moving to.
- We saw much improvement in compliance with the Fit and Proper Person Requirement since our last inspection however, the trust need to ensure they have a robust system in place to ensure executives at the trust meet this regulation at all times.

Leadership of the trust

- The trust board had seven Non-Executive Directors, including the Chair and two associate Non-Executive Directors. The majority of the board had been in post since 2015/16.The The chair was appointed in April 2016. She told us: "it was a real honour to come to Walsall."
- The board meetings were held each month and members of the public could attend and the trust held a public annual general meeting in June each year.

Summary of findings

- At our last inspection, we had found numerous examples of where executives and non-executives at the trust were heavily involved in the operational finer detail. We saw during this inspection this had improved as the trust senior executives told us they understood their role was to hold people to account at the trust and to provide support and direction.
- The Chair told us their main focus was on addressing safety across the trust and in particular in ED and maternity. We were told maternity and ED had received a lot of support since our last inspection but they could not ignore the rest of organisation.
- Staff told us there was a clear management structure and that staff understood the management structure and reported that their managers were visible, supportive, and approachable.
- At our previous inspection some staff told us, the executive leadership at the hospital were not visible. At this inspection, staff told us the CEO facilitated regular staff briefings and was available for individual staff discussions on a weekly basis at one of the coffee shops at the trust.
- The trust senior leadership told us they value the support they had received from stakeholders whilst the trust has been in special measures. Senior staff told us since the last inspection the trust now has systems and processes in place and it now needs the belief and confidence to support this.
- Since our last inspection, the trust had benefitted from an Improvement Director working with the trust at board and senior level. We were able to see the impact of this work through the revised approach the leadership now took.
- Since our last inspection, the trust had developed a clinically led model of senior divisional leadership and governance. Each division was led by a clinical director, lead nurse and lead manager. This triumvirate team took a lead role in the operational leadership and governance in their area. A training program had been provided for staff that were new to leadership. Each service was now focused on making their improvements within the trusts governance framework

Vision and strategy

- The trust's vision was "to provide first class, integrated health services for the people we serve in the right place at the right time".
- Overall, staff understood and were engaged with the trust's vision. Staff knew the trust's priorities and challenges it faced and understood actions the trust were putting in place to mitigate some of these.

Summary of findings

- During the last 12 months, the trust had begun a programme of engagement with the trust clinical leads to develop five-year plans for each service. These were currently in draft form as they had focused on getting the main five-year strategic plan embedded within the trust. A programme of strategy engagement sessions had been running so that teams and clinicians had a clear view as to how their service fitted in with the overall strategy and vision.
- The trust told us there were financial challenges for the local council and clinical commissioning groups. Therefore, the trust anticipated resources to deliver key services that depended on social care would become even more stretched. The trust's response to changes in commissioning and demand was outlined in the draft five-year clinical strategy plans. This included working with primary care to help them identify and support patients at most risk of needing acute care and ensuring the hospital estate was fit for purpose. This detailed plans for major developments in the intensive care unit, maternity, neonatal services, ED (e.g. increased referrals from 2018, and acute ward capacity). The trust's 2017/18 objectives included a commitment to carry out a sustainability review of all services.
- The trust was one of three local NHS trusts that formed part of the Black Country Alliance (BCA) partnership. This partnership aimed to improve health outcomes, improve people's experience of healthcare, and maximise the resources available so together these trusts could meet the needs of people in the Black Country community.
- The trust formed part of the Walsall Together and Black Country Sustainability and Transformation Partnerships (STP) which formed the system wide response to health economy issues.

Governance, risk management and quality measurement

- The trust reported no never events between April 2016 and March 2017. Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Since our last inspection we have seen an overall improvement with regard to reporting and learning from incidents, with the exception of maternity services.
- During this inspection, we found the trust's executive board did not have sufficient oversight into the potential risks to mothers and their babies within maternity services. We identified during

our previous 2015 inspection and during this inspection. We fed back to the executive board and colleagues on the last day of our inspection and shared our concerns regarding risk mitigation and staffing levels in maternity.

- We interviewed members of the executive team during our inspection and we saw they had an oversight of the main issues affecting the trust. However, the trust executive board lacked a full insight into the potential and current risks in maternity services. Maternity staffing levels were not listed as a risk on the corporate risk register. This has since been rectified following our inspection.
- We conducted one additional unannounced inspection following the announced inspection to maternity and found that the same issues remained. We raised our concerns with the trust who said they understood the issues and would begin to put measures in place to mitigate risks to women and babies. However, despite the trust putting certain measures in place, we were not fully assured the trust had implemented sufficient measures quickly enough. We took enforcement action on 7 September 2017 and served a Section 29a Warning Notice.
- Since our last inspection in 2015, we saw governance arrangements across the majority of acute and community services had improved significantly, with maternity services being the exception. Because we had significant concerns about governance arrangements during our last inspection in 2015 we reviewed a significant number of RCA's and associated action plans relating to SI's and section 28 Coroner reports. A CQC specialist advisor for governance and risk visited several core services to test if action plans had been addressed and were in-bedded with staff. Overall, we found staff demonstrated a cohesive approach to risk management and had a good awareness of SIs including coroner reports. We saw the majority of areas made good progress with implementation of action plans and we saw examples of evidence reviewed, with the exception of maternity services. We found accountability arrangements were of particular concern within maternity and the role and responsibility of the head of midwifery needed to be made clear to all staff.
- We were assured that clinical governance, risk and quality management across the majority of services was effective and we were confident that the governance, risk and quality boards influenced and impacted at an operational level. The trust had a new governance lead who was proactive in ensuring that governance and risk at ward and divisional level was aligned

and front line staff were involved in identifying and escalating governance issues on a daily basis through their respective divisions which fed into the trust structure and up to the executive board.

- There were 47 risks on the trust-wide corporate risk register. The trust board had overall responsibility for whether risks were removed from the register. Each risk was also managed locally by the relevant division. The risk register had clear accountability with a risk owner and completion and review dates. The risk register also included existing controls, which were actions the trust had taken to mitigate the risks.
- However, the Corporate Risk Register did not fully represent the full extent of the key risks to the trust and did not include for example, the low staffing levels in maternity.
- The Board Assurance Framework (BAF) was in place dated 4 May 2017. The BAF formed part of the NHS England risk management strategy and policy and is the framework for identification and management of strategic risks requiring further development. For example, we were not assured that the BAF fully reflected all current risks across the trust, specifically the concerns with maternity services. This was because not all maternity risks had been entered onto the corporate risk register and subsequently had not been included on the BAF. This meant we were not assured that all risks were fully identified, understood and managed appropriately.
- The trust held clinical governance committee meetings. These were held to enable the board to have oversight and assurance that high standards of care were provided by the trust and that adequate and appropriate governance structures, processes and controls were in place throughout. We reviewed minutes from these meetings the main risks to services across the trust were discussed and actions agreed. We saw the mortality report was also presented and discussed at this meeting. We saw some risks to maternity services had been discussed in the April 2017 meeting.
- The trust had a clear strategy to recover the trusts' financial status through the cost improvement plan (CIP). There was detailed oversight at the performance and finance committee. However, the organisation would have a deficit of £22m in 2016/17, which was much higher than the original planned deficit of £6.2m, and was in excess of the control total agreed with NHS Improvement. This was compared to a deficit of £12.9m for 2014/15.

Culture within the trust

Summary of findings

- Staff across a range of services at the trust reported a much more positive and open culture which had changed for the better since our last inspection.
- Staff told us they were proud to work for the trust and enjoyed working there due to the 'family feel'.
- Since the implementation of the clinically led model at the trust, ED was now taking ownership and trying to find solutions to their own issues.
- At our previous inspection, we saw staff morale was low across numerous hospital departments and wards. At this inspection, we found staff morale had significantly improved. For example, in ED managers and staff all displayed a positive culture of wanting to improve the service they provided to their patients. They were proud of the service and were keen to tell us about and show us improvements they had made since our previous inspection in September 2015.
- Staff across the majority of services where we saw improvements demonstrated an awareness they were on an 'improvement journey' but more work was still required to drive improvement.
- We saw staff morale was much improved since 2015 and staff were keen to tell us what they did well at the trust and understood they were on an improvement journey.
- However, there remained in maternity a negative culture despite this being raised at our previous inspection. We were told there was a difficult culture between some staff, which appeared to be obstructing change. We were told this had the potential to affect clinical practice. We observed and staff reported to us an oppressive culture that some described as bullying in maternity which we corroborated through a number of interviews and discussions with staff. We observed that staff might be less likely to report issues of concern due to the response they receive from senior staff. Student midwives told us that the culture was having an impact on recruitment and retention.
- We asked senior staff what was different in terms of culture since we last inspected. We were told staff now felt enabled to raise concerns. Previously staff did not share issues and felt as if they could not state what the issues were. Senior staff told us the culture in the trust had improved and poor behaviour was now tackled but they were not confident this was actually managed properly. The trust had seven people in post who were trained to conduct investigations.
- We interviewed the Freedom to Speak up Guardians whose role it is to work alongside trust leadership teams to support the organisation in becoming a more open and transparent place

to work, where all staff are actively encouraged and enabled to speak up safely.We heard numerous examples where staff had raised concerns, concerns were taken seriously, investigated and appropriate action taken. The member of staff then received confidential feedback on the outcome.

- The trust's sickness levels between January 2016 and December 2016 were higher than the England average. Rates improved in the early part of the year in line with the England average, before getting worse over the rest of the year.
- We saw one of the wards had a staff attendance rate of 97% and leaders from other departments had asked how this had been achieved. Staff had been given a very specific role, which was discussed regularly with ward leaders, highlighted their achievements so felt integral to the running of the ward. Staff now had pride in their work and were reluctant to take time off.

Equalities and Diversity – including Workforce Race Equality Standard

- As part of the new Workforce Race Equality Standard (WRES) programme, we have added a review of the trusts approach to equality and diversity. The WRES has nine specific indicators organisations are expected to publish and report against and implement action plans to improve the experiences of its Black and Minority Ethnic (BME) staff. As part of this inspection, we looked into the WRES and race equality within the organisation.
- Data for Walsall as a community suggests that 13.6% of people living in the Walsall CCG area are from a BME background.
- The latest WRES report by the trust was submitted in August 2016. It shows that 24.8% of staff are from a BME background.
- The trust board BME representation was made up of, 16.7% of the executive team and 33.3% of the non-executive team.
- As at 31 March 2016; we saw that 38.2% of the trusts senior managers are BME compared to 24.8% of the overall workforce from a BME background.
- The NHS Staff Survey results for 2016 for equality and diversity showed the trust score in relation to the percentage of staff who had experienced discrimination in the last 12 months remained above (worse than) average at 13%. This saw a decrease from 14% to 12% for BME staff experiencing discrimination, which is below the national average of 14% with white staff considered average.
- The proportion of staff that considered that the trust provided equal opportunities for career progression or promotion remained below (worse than) the national average at 82%.

When this was broken down by ethnicity, the proposition that the trust provided equal opportunities was supported by 85% of white respondents and 71% of BME respondents, an improvement of 3% for BME staff since the previous survey.

- The relative likelihood of BME staff entering the formal disciplinary process compared to White staff is 1.5 times greater.
- We saw the trust were aware of this data and had actions in place to reduce any variation.
- We saw the trust commissioned an external review into equality and diversity provision across the trust in October 2016. A number of recommendations were made and the trust's equality and diversity inclusion steering group recommended their priorities for 2017/18 to the trust board. The trust conducted a gap analysis.
- All staff received equality and diversity training as the trust was trying to embed inclusion following poor staff survey results regarding equality and diversity. The trust acknowledged there was still work to be done to embed equality and diversity in all processes across the trust.
- We saw there was a diversity wall in the wellbeing hub to give key equality and diversity messages.
- The trust had an equality, diversity, and inclusion implementation group, which reported to the equality, diversity, and inclusion committee every two months.

Fit and Proper Persons

- Since 27 November 2014, all NHS bodies that are required to register with the Care Quality Commission (CQC) must comply with Regulation 5 of the HSCA; known as the fit and proper person requirements when making appointments to director level positions. Providers must take proper steps to ensure that their directors (both executive and non-executive), are fit and proper for the role. Directors, or equivalent, must be of good character, physically and mentally fit, have the necessary qualifications, skills and experience for the role, and be able to supply certain information (including a Disclosure and Barring Service check and a full employment history).
- In our previous inspection in September 2015, we found the trust had failed to implement the fit and proper person checks and associated tests necessary to meet this requirement. In addition, the trust did not have a Fit and Proper Person policy in place.
- The trust had implemented a Fit and Proper Persons Requirement Policy on 24 September 2015, two weeks following our previous inspection.

- We reviewed seven executive (both executive and non-executive) personnel files. We found five out of seven files fully complied with the Fit and Proper Person Regulation as they contained all of the necessary documents including DBS checks and references.
- Two files did not have up-to-date DBS checks. This was highlighted to the HR Director during our inspection who promptly investigated this issue. It was identified there was an issue with the competencies on the electronic staff record of these staff members which meant it did not flag when the DBS check was due. The trust took remedial action to address this breach by requesting DBS checks for outstanding staff and we are assured that all files we looked at are now fully compliant.
- We randomly selected a number of staff files to review. All nurses had valid NMC PIN registration numbers and medics were registered with the GMC without any restrictions on their practice; demonstrating that staff at the trust had a valid registration with their professional body.

Public engagement

- The chief executive told us during the trust presentation and we saw referenced in board meeting minutes, a patient or their relative was invited to each board meeting to share their patient story with the board. These patient stories were brief descriptions of what people, particularly patients, said about the services at the trust. They could describe either positive or poor care experiences. This gave the board an insight into patient's experiences at the trust.
- The trust had an answerphone system to record patient views that was being trialled in the outpatient department. Patients were encouraged to leave (often anonymously) a voicemail message of their experiences in the department. These were both positive and negative. We heard some of these messages and saw how the trust responded to the issues raised. We saw that the outpatient service used these as a learning opportunity in their team meetings to review the quality of care provided. The trust intended to roll this out for wider use.
- We saw that the trust board reviewed samples of these at board meetings. Board members we interviewed said these were a useful opportunity to hear directly from patients.
- The trust took part in the NHS Friends and Family Test. The Friends and Family Test (FFT) is a feedback tool to enable people who use NHS services to provide feedback on their experience. The trust had an easy read FFT comment card and cards suitable for children and young people so they do not miss opportunities to gain the views of a range of patients.

- It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice. We saw the trust had an easy read card.
- The trust's Friends and Family Test performance (% recommended) was generally about the same as the England Average between April 2016 and March 2017. In latest period, March 2017, trust performance was 89% compared to an England average of 95%.
- The trust ran a 'In Your Shoes' initiative which involved asking patients, families and carers who had used Walsall Healthcare services in the last 12 months to talk about their experiences, whether good or bad. In response to the feedback received the trust strove to improve communication to patients about waiting times which had improved with real time updates on a TV screen in the waiting room in the Emergency Department.
- In surgery, the Matron for elective surgery held a "Tea with Matron" session every Thursday afternoon for patients to sit with matron and ask any questions they had about their surgery.
- The trust had developed a Patient Experience Strategy 2016 - 2020 to deliver an improved patient experience. This focused on the need to provide an improved patient experience in line with national guidance. It outlined the value in working with patients and the public and how the patient voice will inform the work of the trust.
- The trust had close links with Healthwatch Walsall who collated public views of the trust. The trust commissioned Healthwatch Walsall to conduct an independent research project into the standards of care at the hospital April 2017. For example, they asked patients about the hospital cleanliness and staff demeanour.

Staff engagement

- Senior staff from ED told us when the trust was rated inadequate and were placed in special measures in February 2016 it was like a grieving process and had to go through feelings of anger, upset, and acceptance. The trust held workshops in ED involving a range of staff such as porters, receptionists and nurses.
- We saw the staff lead for ED had produced a 'make the difference calendar for 2017 for staff. It included useful prompts to encourage staff to think about their values and behaviours

linked to special days that month. For example, for April 2017 it stated 'what could your team do to show respect for faith or belief in your services?' For October 2017, the prompt stated 'how do we make sure everyone's culture and heritage is valued in what we do?' The calendar also highlighted what values staff should expect from each other and managers. Details of who staff should contact if they felt they were being treated unfairly was also included.

- The trust had a health and wellbeing hub working with partners across Walsall to protect and improve colleagues' health and wellbeing at Walsall Healthcare NHS Trust.
- The trust took part in the NHS National Staff Survey, organised by NHS England carried out from October to December 2016. The questionnaire was sent to all trust staff and 1730 staff responded, equating to a 42% response rate for the trust, which was slightly higher than the national average for acute trusts at 40%. Walsall Healthcare NHS trust had seen a growth rate of around 20% compared to the 2015 survey.
- In the NHS Staff Survey 2016, examples of questions for which the trust performed better than other trusts were:
  - Percentage of staff appraised in the last 12 months (88% compared to the England average of 86%).
  - Percentage of staff/colleagues reporting most recent experience of harassment, bullying, or abuse (70% compared to the England average of 71%).
  - Support from immediate managers (the trust scored 3.73 compared to the England average of 3.74).
- The questions for which the trust performed worse than other trusts were:
  - Percentage of staff reporting errors, near misses, or incidents witnessed in the last month (86% compared to the England average of 91%).
  - Percentage of staff agreeing that their role makes a difference to patients / service
  - Users (86% compared to the England average of 91%).
  - Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (18% compared to the England average of 13%).
- The staff survey engagement score (a measure of how well engaged staff are with the trusts overall work) for this trust was 3.62, which is worse than the average engagement score for trusts in England of 3.80.
- The trust appointed three Freedom to Speak Up Guardians in December 2016. We interviewed the Freedom to Speak up Guardians whose role it is to work alongside trust leadership teams to support the organisation in becoming a more open

and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.We heard numerous examples where staff had raised concerns, concerns were taken seriously, investigated and appropriate action taken. The member of staff then received confidential feedback on the outcome.

- The guardians worked together on a part-time basis to be available to colleagues across the organisation. They had direct access to the Chief Executive if required. The guardians had a non-executive lead on to oversee the work of the guardians to improve openness within the trust.
- Senior staff told us the guardian's role was well respected and their services well utilised by staff across the trust as staff felt like they were being listened to.
- In November 2016, the trust held their first Listening into Action (Pass it on Event. The aim of
- Staff told us that they had seen many positive improvements since the implementation of LIA. Staff felt this had improved culture at the trust as well and they now felt that their views and opinions were valued and respected.
- In November 2016 the trust, held their Annual Colleague Awards Event, which included awards such as Quality and Safety Award, Rising Star Award, Exceptional Achievement Award. Individual staff, teams, departments, or entire wards could be nominated for these awards.

Innovation, improvement and sustainability

- The outpatients department had introduced a text message reminder system for all outpatient appointments to reduce the 'did not attend rate'.
- A neighbouring acute trust was moving to one larger hospital and Walsall Manor's ED was expecting to see an increase in its patient numbers as a result. Senior managers were aware of this risk, and were addressing the potential for increased workload with their trust board and clinical commissioners, to ensure they had sufficient funding, enough staff and appropriate-sized premises to cope with the increased demand.
- In maternity and gynaecology, the service had secured £48,000 for training which was used to send staff on a number of external training courses such as PROMPT training to develop the service's emergency drills study day and human factors study days.
- In services for children and young people, a number of improvement initiatives had been implemented. For example,

the service had developed rapid access clinics to ensure an urgent senior paediatric review/opinion for children who need urgent review and could not wait for a routine outpatient consultation.

- In diagnostic imaging, we saw the service was planning to begin radiography led discharge in September 2017. The service was currently finalising the clinical governance arrangements around this. This would enable advanced practitioners to discharge patients who had x-rays below the elbow or knee if there was no fracture seen which would help to increase the speed of patient discharge.

Overview of ratings

Our ratings for Manor Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good

Our ratings for Walsall Healthcare NHS Trust

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

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	☆ Outstanding	Good
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Good	Good
Community health inpatient services						
Community End of Life Care services	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Community health urgent care services (MIU)						
Community heath dental services						
Special care dental services						
Surgery – satellite sites						
Outpatient and diagnostic imaging services – satellite sites						
Other specialist services						
Overall Community	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Outstanding practice and areas for improvement

Outstanding practice

ED

- Staff and patients' relatives all told us the ED dementia lead nurse was making significant improvements for patients living with dementia while they were being cared for in the department.
- Staff told us about a seriously ill patient who had been brought in to the department by ambulance a few days before their son's wedding. Because there was a danger the patient may not have lived long enough to attend the wedding, staff made arrangements for a small wedding ceremony to take place in the department's relatives' room, to allow the patient to see their son married.

Outpatients and diagnostic imaging

- Outpatients and diagnostic imaging staff had made significant progress since the previous inspection in November 2015. The culture in the outpatients department had changed considerably for the better, with local staff taking responsibility and ownership for their own areas and specialities.
- Development opportunities amongst junior nursing and care staff were very good across outpatients. Senior nurses had recognised the limited opportunities for promotion, therefore had put measures in place to develop staff within their current roles. For example, the staff nurses now undertook auditing in each other's areas and formulated action plans together. These were the responsibility of the staff nurses to ensure improvements and take ownership of problems and solutions.

End of Life Care

- The service provided access to care and treatment in both the acute and the community settings 24-hours a day, seven days a week.

Community End of Life Care

- Community engagement by the Walsall Palliative Care Centre was exemplary. A panel of patients and patient relatives had reviewed all the content and style of documentation such as the advanced care plan and the individualised care plan. This meant that in addition to following national guidelines on End of Life care the documents also reflected the needs and wishes of the local population. It also meant that people in the community were able to understand the documents. As outlined in the report a number of documents produced by the senior managers had won national recognition and awards.
- Ongoing development of the transition service for young people was based on the experiences of those young people. An information film following the real-time transition of patients had been produced. This was in post-production before being made available to young people, their families and external healthcare professionals. The information included an insight into the medical, physical and social support provided in adult services based around the Walsall Palliative Care Centre.
- Audit of patient records was conducted on a monthly basis, feedback was provided to teams on their performance. Where improvements were required teams were asked to reflect on their own practice and report back to quality assurance meetings how they intended to improve. This had resulted in raising the profile of End of Life Care throughout the service. Innovative practice from teams was highlighted and circulated to all.

Community health services for children, young people and families

- The speech and language therapy team had won the NHS England Allied Health Professional Award for associate of the year 2017. This was specifically for the 'little learners' group initiative which iivolved 90 children, their parents/carers and teaching assistants.
- The transition team had been nominated for three national awards and had been highly commended by the Health Service Journal in 2016.
- Nursery nurses in the health visiting team had been nominated by school children for an educational video developed by the team called "help me I'm hairy". They were able to train the trainers to deliver the content of the education sessions and were undertaking training sessions with teachers at the time of the inspection.

Outstanding practice and areas for improvement

- The teenage pregnancy service had developed a website called 'Easy SRE', a toolkit of resources to support sex and relationships education.

Community health services for adults

- An alert system had been developed to enable the long-term condition teams to be notified immediately when vulnerable adults i.e. those at risk of hospitalisation, presented in accident and emergency or any ward area in Walsall Manor Hospital. An automatic e-mail alert was generated and sent to the place based team community nursing mailbox and community matrons.
- The rapid response team to identify patients who had an admission to hospital avoided following discharge from the service. An initial audit in October 2015 showed 47% of patients were admitted 30 days after discharge from this service. The audit identified poor step down to community teams and too rapid a discharge from the service. Information we saw showed that improvement had been made and following a period of stabilisation there were now 13% to 14% of patients admitted to hospital within 30 days of discharge from the rapid response team between September 2016 and March 2017.

Areas for improvement

Action the trust MUST take to improve

Maternity and Gynaecology

- Risks are explained when consenting women for procedures.
- The service uses an acuity tool to evidence safe staffing.
- Action plans are monitored and managed for serious incidents.
- Lessons are disseminated effectively to enable staffing learning from serious incidents, incidents and complaints.
- Staff follow best practice national guidance.
- Ensure staff are compliant with the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- VTE risk assessments are completed.

Urgent and Emergency Services

- Take action to improve ED staff's compliance with mandatory training.
- ED completes the action plan compiled following the CQC inspection carried out in September 2015.

Critical care

- Plans are in place for staff within the critical care unit to complete mandatory training. This includes appropriate levels of safeguarding training.
- All staff working within the outreach team are competent to do so.

Children and young people

- All local guidelines are updated and regularly reviewed for staff to follow.

Outpatients and Diagnostic Imaging

- Staff undertake required mandatory and safeguarding training as required for their role.
- All staff within outpatients have the required competencies to effectively care for patients, and evidence of competence is documented.
- All staff receive an appraisal in line with local policy.
- Patients medical records are kept secure at all times.
- All outpatient clinics are suitable for the purpose for which they are being used.

End of life care

- Attendance for mandatory training is improved.
- Undertake required safeguarding training as required for their individual role.
- All staff are trained and competent when administering medications via syringe driver.

Medical care

- Mandatory training is up-to-date including safeguarding training at the required level.
- There are sufficient numbers of suitably qualified, competent, skilled and experienced staff to keep patients safe.

Surgery

- All professional staff working with children have safeguarding level 3 training.

Outstanding practice and areas for improvement

- All staff are up to date with safeguarding adults.
- The safeguarding adults and safeguarding children policies are up to date and include relevant references to external guidance.
- Patient records are completed, that entries are legible and each entry is signed, dated with staff names and job role printed.
- All shifts have the correct skill for wards to run safely.
- All staff are up-to-date with mandatory training.

Community Services for Children and Young People

- Ensure blind cords are secured in all areas where children and young people may attend.
- Ensure patient records are kept confidential and secure.
- Continue to follow standard operating procedures with medicines in special schools.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Part 3 Regulation 18 Staffing 18(2)(a) - Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. 18(1) Sufficient numbers of suitably qualified, competent, skilled, and experienced persons must be deployed in order to meet the requirements of this part. There were high levels of nursing staff vacancies across acute services. This meant the provider was not providing sufficient numbers of suitably qualified staff to keep patients safe.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12: Safe Care and Treatment 12 (2) (a) Venous Thromboembolism assessments were not carried out for all patients at risk.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

12 (2)(a)

Not all staff were compliant or completed timely

assessments for patients- in accordance with

the Mental Capacity Act 2005. This includes best interest decision making; lawful restraint; and, where required, application for authorisation and for

Deprivation of liberty through the Mental

Capacity Act 2005 Deprivation of Liberty

Safeguards or the Court of Protection.

12.(2)

The critical care environment had only one isolation room. This provision was not meeting the needs of patients so was not sufficient to maintain safe management of infectious patients.

12(2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely

Staff were not up-to-date with mandatory training. There were a number of modules that had completion rates significantly lower than the trust's target.

Regulations 12(1), 12(2)(e), 12(2)(h).

Blind cords were not secured in all of the rooms at the child development centre.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17: Good Governance 17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Staff were not consistently completing patient records. There were trust documentation that was not completed

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulation 13: Safeguarding

1) Service users must be protected from abuse and improper treatment in accordance with this regulation

2) Systems and processes must be established and operated effectively to prevent abuse of service users

Safeguarding training completion rates were low for both medical and nursing staff. Not all staff were trained in level 3 safeguarding children, which is a requirement set by the Intercollegiate document (2014).

The lack of training caused the potential risk of service users not always being protected from abuse and improper treatment.

This section is primarily information for the provider

Requirement notices

and staff were not always signing entries. There were a number of entries where there were signatures, printed names, dates, and job roles missing. Not all records were legible or were kept secure at all times.

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

10(1), 10(2)(a).

Service users must be treated with dignity and respect. The registered person must ensure the privacy of the service user.

Patients' records were taken home by the community children's nursing team when they were not returning to the office. We were not assured of the confidentiality or security of records.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **HSCA 2008** **(Regulated Activities) Regulations 2014,** **Regulation 18 (1)** The registered provider did not ensure there were adequately qualified staff across maternity services to meet the needs of woman and their babies to protect them from abuse and avoidable harm.

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **HSCA 2008** **(Regulated Activities) Regulations 2014,** **Regulation 12 (2)(b)** The registered provider did not Monitor, record and escalate concerns for Cardiotocography (CTG) to protect women and their babies from abuse and avoidable harm

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **HSCA 2008** **(Regulated Activities) Regulations 2014, Regulation 13(2): Safeguarding**

This section is primarily information for the provider

Enforcement actions

Safeguarding training across maternity services was insufficient to protect women and babies on the unit who may be at risk.

We have issued a Section 29A Warning Notice to the Registered Provider, as the quality of health care provided for the regulated activities listed requires significant improvement.